2017

The Effects of Session and Outcome Rating Scales Used in a Wraparound Setting

Alexandra Giatrelis
Antioch University, New England

The Effects of Session and Outcome Rating Scales Used in a Wraparound Setting

by

Alexandra Giatrelis

B.A., Fairfield University, 2012
M.S., Antioch University New England, 2015

DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of
Doctor of Psychology in the Department of Clinical Psychology
at Antioch University New England, 2017

Keene, New Hampshire

ANTIOCH UNIVERSITY
NEW ENGLAND

Department of Clinical Psychology

DISSERTATION COMMITTEE PAGE

The undersigned have examined the dissertation entitled:

THE EFFECTS OF SESSION AND OUTCOME RATING SCALES USED IN A WRAPAROUND SETTING

presented on July 27, 2017

by

Alexandra Giatrelis

Candidate for the degree of Doctor of Psychology
and hereby certify that it is accepted*.

Dissertation Committee Chairperson:
Martha Straus, PhD

Dissertation Committee members:
George Tremblay, PhD
Gina Pasquale, PsyD

Accepted by the

Department of Clinical Psychology Chairperson
George Tremblay, PhD

on **July 27, 2017**

*Signatures are on file with the Registrar's Office at Antioch University New England.

Acknowledgements

There are so many people who have walked with me through this journey. It took a village to get me to where I am today, and I am so thankful for mine. To my parents: Thank you for showing me your constant support, for remaining patient with me during times when that was likely not an easy feat, and for sometimes being more confident in me than I was in myself. To my siblings: Thank you both for keeping me young, for maintaining my level of "coolness" with my younger patients by educating me on the latest and greatest teenage and young adult trends, for inspiring me through your dedication to academics and to working hard, and for just being you. To my future husband, David: thank you for joining me on my journey through life, and for supporting me every step of the way. Thank you for insisting that I remain committed to my goals, even when my own enthusiasm dwindled. You are already an amazing life partner, and I can't wait to see what our future holds!

To my second family, the Rorsharks: There will never be another group of individuals who understand as much as we do what this process was like. Thank you for making me laugh during our countless hours of classes when all I wanted to do was cry, thank you for comforting me when crying felt like the only option, and thank you for countless memories and adventures that I will never forget.

Thank you to the many academic supports who encouraged me not only professionally, but also personally. Thank you first and foremost to my dissertation chair, Martha Straus, Ph.D., who tirelessly provided me with loving and encouraging feedback throughout my time at Antioch, and who helped me to feel confident enough to succeed. Thank you to my dissertation committee members, George Tremblay, Ph.D. and Gina Pasquale, Psy.D., who each offered invaluable support and guidance during my time at Antioch. All three of my committee members

have been extremely inspiring examples of what I hope to one day become. Thank you to my clinical supervisors over the past several years who have contributed to my professional growth and confidence: Gregory Williams, Ph.D., Kathryn Patterson Psy.D., and Angel Roubin, Psy.D. Without your commitment to my learning, I do not know where I would be today.

I did it!

Table of Contents

List of Tables

List of Figures

Abstract

This study investigated the usefulness of session and outcome rating scales within a wraparound program in New England. The extensive needs of youth with serious emotional disturbance (SED) categorizations and their families require highly coordinated systems of care that not only deliver adequate services, but contend with the momentum of often contentious and unsuccessful relationships these families have typically experienced with social service systems. Outcome and session rating scales, along with measures of fidelity, hold the potential to provide rapid feedback on both outcome (outside of sessions) and working alliance (within sessions), as well as the consumers' perspective on the quality of the services being provided. I first review current literature illuminating the gravity of receiving an SED diagnosis, the consequences for those that it affects, and the inadequate current levels of practice for this population. I then review literature related to the wraparound model, its effectiveness with treating this population, and the development and utility of session and outcome rating scales, as well as fidelity measures, within this model of care. I then describe research questions addressing relationships between (a) consumer perceptions of their working alliance with wraparound coordinators and child outcomes, (b) consumer perceptions of their working alliance with wraparound coordinators and observer-rated fidelity to the Wraparound model, and (c) the use of a session rating scale with wraparound coordinators' perceptions and responses to their use in session. Methods for answering these questions are then outlined through both the use of data collected from 44 families participating in the wraparound program in New England, as well as interviews that were conducted with the three wraparound coordinators and the one wraparound coach who are involved in the project. Findings were discussed in terms of their usefulness for improvement of service delivery to this high-risk population in a wraparound setting.

Keywords: wraparound, serious emotional disturbance

The Effects of Session and Outcome Rating Scales Used in a Wraparound Setting

This study examined the usefulness of session and outcome rating scales in a wraparound setting. "Wraparound" addresses the array of family needs that are associated with a diagnosis of serious emotional disturbance (SED) in a young person, and describes the coordination of multiple service delivery systems, which help them capitalize on their strengths and better manage their challenges. Consistent with the model's strong commitment to tailoring services to each individual family, outcome, process, and fidelity measures are used in order to help wraparound coordinators to gain a better understanding of both parent and child perspectives on the child's progress, their perceptions of their working alliance with their wraparound coordinator, and their perceptions of the care they are receiving. Session, outcome, and fidelity rating scales that are administered to each family throughout treatment could provide coordinators with useful information about the way they delivered the intended service, which they may have otherwise been unaware of. By using the wraparound model to treat SED youth and their families and measuring progress with session, outcome, and fidelity rating scales, coordinators may then have feedback they can use to adjust their interventions. By doing so, they may provide more effective treatment leading to improved outcomes.

Literature Review

Diagnosis and Treatment of Serious Emotional Disturbance

Serious emotional disturbance (SED) is one of 13 possible categories of disabilities under the Individuals with Disabilities Education Act (IDEA: Eberharter-Maki, Western Regional Resource Center, & Idaho Department of Education, 1996). Children are categorized this way in the school setting where one third to one half of SED youth requires special education services (Forness & Knitzer, 1992). Although multiple sources have estimated that 9% to 13% of children

and adolescents have an SED diagnosis, a much smaller percentage receive appropriate services; families often struggle to access an adequate level of care for their SED youth (Copp, Bordnick, Traylor, & Thyer, 2008). Between the 1970s and 1990s, Leichtman (2006) noted significant increases in SED diagnoses among youth. In particular, children living in poverty who were attending under-resourced school systems received this diagnosis more frequently than their higher socioeconomic status peers. It is likely, therefore, that impoverished SED youth pose unique challenges for both families and school systems.

Although broad and somewhat controversial due to conflicting views about how and if children should be labeled, the following criteria are used to assign an SED diagnosis. Under IDEA, a serious emotional disturbance is said to be a disorder where one or more of the following features is present for an extended period of time, is pronounced, and affects academic achievement:

> (a) an inability to learn which cannot be explained by intellectual, sensory, or health factors; (b) an inability to build or maintain satisfactory relationships with peers and teachers; (c) inappropriate types of behavior or feelings under normal circumstances; (d) a, general pervasive mood of unhappiness or depression; or (e) a tendency to develop physical symptoms or fears associated with personal or school problems. (Forness & Knitzer, 1992)

Although there is a moderately high prevalence rate of SED among youth, considerable time often passes between identification of youth with SED and providing them with sufficient and appropriate services. Even though families and schools typically notice that there is an emotional or behavioral issue by the time a child is approximately six years old, service delivery is often not initiated for another two years on average (Hocutt, McKinney, & Montague, 2002).

It is possible that families and schools hope that the issue will resolve on its own, despite the risk that delay of intervention will instead exacerbate and solidify the child's pattern of coping and performance difficulties. In addition, delay of intervention has other adverse consequences, including the possible increase in hostile relationships between families and schools or other agencies (Hocutt et al., 2002).

Families with a SED youth also face many stressors that potentially compromise the care they are able to provide for their child. Research suggests that families who care for relatives with physical, emotional, behavioral, or mental disorders endure a considerable amount of strain related to their responsibilities. The strain that caregivers of SED youth experience is associated with the level of services that their children receive; Higher levels of strain have been correlated with increasingly restrictive levels of treatment and higher costs overall (Heflinger & Taylor-Richardson, 2004). Other studies have similarly shown that caring for SED youth affects family functioning overall, increasing conflict and weakening relationships within the family. Financial strain and social isolation may further contribute to increased stress levels within family systems caring for SED youth (Corliss, Lawrence, & Nelson, 2008).

Children with SED labels can manifest both internalizing and externalizing symptoms and typically also carry DSM diagnoses including (i.e., conduct disorders, affective disorders, anxiety disorders, and attention-deficit disorders; Soenen, D'Oosterlinck, & Broekaert, 2013). The difficulties SED youth tend to have with regulating behaviors and moods present a considerable challenge to successful functioning in social, academic, and occupational domains. This combination of challenges may be troubling for others to observe or tolerate, further reducing the support and interaction available to SED youth and their families (Armstrong, Dedrick, & Greenbaum, 2003). In addition, according to a literature review conducted by

Vernberg, Roberts, and Nyre (2007), SED youth tended to have unfavorable academic outcomes, as less than 50% of this population complete high school. Also during young adulthood, SED youth are more likely to engage in risky behaviors such as substance abuse, criminal activity, and unsafe sexual activities (Armstrong et al., 2003). SED youths' high rates of academic failure naturally lead to more erratic and lower-paying employment, and increased demands on social services over time (Armstrong et al., 2003; Vernberg et al., 2007).

Typical Interventions for Behavior Problems are Not Often Adequate for SED Youth

Beginning in the early 1980s, children's mental health service systems were challenged in a national report where it was argued that two thirds of SED youth were not being treated properly, or at all. Jane Knitzer, Ph.D. surveyed mental health departments in all 50 states and the District of Colombia, and received formal responses from 43 states and the District of Colombia. Her survey requested information about many aspects of children's mental health services including organizational structure, financial arrangements, and services rendered to children as well as cutting edge interventions and approaches for treating this population. The results of Knitzer's study were published in *Unclaimed Children* in 1982 (Davis, Yelton, Katz-Leavy, & Lourie, 1995). Hansen, Litzelman, Marsh, & Milspaw (2004) identified Jane Knitzer's 1982 report for the Children's Defense Fund as a seminal study on multiple-systems collaboration. In *Unclaimed Children*, Knitzer is quoted as remarking, "Of the three million seriously disturbed children in this country, two-thirds are not getting the services they need. Countless others get inappropriate care. These children are 'unclaimed' by the public agencies with responsibility to serve them" (Knitzer, 1982, p. ix). This report prompted the formation of the Child and Adolescent Service System Program (CASSP), which sought to assist states in better addressing the needs of this population through promoting improvements in the services

being provided, as well as in the coordination of such services (Painter, 2012).

By the late 1980s, approximately 125,000 SED youth were receiving treatment in residential facilities, and by the close of the 20th century, the number of children had doubled to almost 250,000. Although more SED youth were receiving treatment, researchers like Knitzer criticized residential models of care for their lack of sensitivity to the needs of each family (Leichtman, 2006). Research also suggested that removing children from their families and placing them in isolated treatment centers implied to SED youth and families that the children were solely responsible for the issues that had arisen in their lives, and that the responsibility for change therefore rested on their shoulders alone (Robinson, 2000). In addition, this model failed to assist with reintegrating youth back into their homes successfully; the outcome research suggested that the gains the youth had made while in residential care were not maintained upon discharge (Leichtman, 2006).

In addition to the astronomical cost of placement, research revealed that these unsatisfactory outcomes were due to the lack of family involvement while the child was in care, the inadequate teaching of adaptive skills for transitioning back home, as well as insufficient planning for aftercare. By the 1990s, residential programs had decreased in popularity, and service delivery systems within the United States were being pushed to consider other options in the community. Such alternatives included medication management to combat disruptive behavior and affective instability, intensive outpatient services, family therapy, and wraparound services (Leichtman, 2006).

Common goals of traditional community-based treatment in psychotherapy for SED youth are focused on helping to improve on-task behaviors, developing social skills, and decreasing unwanted behaviors (Kutash, Duchnowski, Sumi, Rudo & Harris, 2002). Notably,

such focus on treatment of individuals without comparable attention to family and community-based interventions has resulted in poor outcomes. Further, Kutash et al. noted a discrepancy between the research on successful treatment options for SED youth and the current level of practice. According to these authors, this discrepancy has led to a lack of comprehensive approaches to treatment. Moreover, psychology's continued focus on deficit-oriented approaches has left little room for the incorporation of strengths-based treatment strategies for these most vulnerable youth and families (Cox, 2006). Despite these generalizations about community mental health treatment as a whole, it is important to acknowledge both the overwhelmed service delivery system, as well as the solid efforts being made by clinicians to shift their approach in order to collaborate more frequently with community-based resources.

Viewing the SED label as the child's problem is inaccurate and inadequate in many ways, if the exploration does not also address the systemic causes of the child's suffering. For example, an analysis of existing data from various locations across the United States and Puerto Rico conducted by Costello, Messer, Bird, Cohen, and Reinherz (1998) sought to identify commonalities among SED youth. Results suggested that SED prevalence rates were almost twice as high in youth coming from lower socioeconomic statuses as compared with youth from higher socioeconomic statuses. Socioeconomic status was the strongest correlate of SED diagnosis when compared with gender and age. In addition to the association between SED youth and low-income families, a SED label has also been associated with families who have public insurance coverage or no coverage at all, as well as those who identify as African American or Hispanic (Mark & Buck, 2006).

Additionally, studies have shown that children who are exposed to violence are at risk for emotional and behavioral issues as well as poor social functioning, all of which are

characteristics of the SED label. Being victims of abuse, as well as witnessing violence between others has the potential to compromise proper development and adjustment (Rudo, Powell & Dunlap, 1998). Research conducted by Anda et al. (2006) about the long-lasting effects of adverse childhood experiences suggests that exposure to traumatic experiences such as abuse during childhood are strongly related to the prevalence and risk of the development of affective disturbances later on. Furthermore, as the Adverse Childhood Experiences score increased beyond 4, the risk of panic, anxiety, depression, and hallucinations increased. This population also tended to perceive their stress levels as extremely high; they had increased difficulty controlling their anger, and they were at greater risk for engaging in violent behavior both in general and with future partners. The development of neural networks and the neuroendocrine system becomes compromised for individuals who endure adverse experiences in childhood, which prevents them from being able to develop fully functioning regulatory capabilities (Anda et al., 2006).

Therefore, children who endure maltreatment are more likely to be labeled as SED. Notably, also, families who are involved with child welfare agencies tend to contain within them parents who also have fairly extensive needs, including untreated substance abuse and mental illness of their own. Parental substance abuse has been associated with risks to children's physical and emotional safety, inadequate development, and lack of well-being. This issue becomes cyclical in nature; as SED youth become increasingly activated by their parents' inadequate parenting they require substantial support and resources that the parents, in turn, have increasing trouble providing (Becci, Brook, & Lloyd, 2015). Traditional mental health interventions sometimes struggle to address larger systemic issues such as poverty, lack of access to adequate resources, exposure to violence, and parental substance abuse and instability. This

likely occurs as a result of other work-related demands being placed on service providers, as well as a lack of available funding that could otherwise assist in addressing some of these issues.

Multiple Systems Provide Services to SED Youth at the Cost of Efficiency

Youth who have been categorized as SED are likely to have co-occurring needs in several domains, requiring multiple agencies' involvement and participation in treatment. In addition to requiring mental health services, over time, involved children and families are likely to require substantial support from public schools, the juvenile justice system, primary health care, substance abuse services, and child welfare services, in order for the most effective and comprehensive care to be delivered (Hansen et al., 2004; Malmgren & Meisel, 2002; Walrath, Nickerson, Crowel, & Leaf, 1998). Too often, these systems lack the coordination necessary to effectively serve SED youth and their families. As a result, families are confronted with multiple agencies, each with its own agenda and intended to serve a particular purpose in treatment, but without an overarching vision, and no mechanism that would enable them to work together efficiently. Further, many of these systems and their employees are not particularly well equipped to address mental health related issues and may compound the difficulties when they are called upon by families of SED youth to meet their extensive needs. Consequently, service delivery can become less efficient if agencies are providing competing, overlapping, and ineffective intervention strategies (Hansen et al., 2004). To address this concern, some community mental health centers have begun to make efforts to advance service delivery to children and their families through the use of case managers and comprehensive team meetings.

Oftentimes, even when families understand that their SED youth require services from multiple systems, they simply do not have the resources necessary to be able coordinate this effort across the various systems on their own. Coordination of so many different services has

proven to be overwhelming for families, leading to unintentional gaps in SED youth's treatment, a lack of connection between systems, and an overall failure to provide for the extraordinary needs of this population (Copp et al., 2008; Hansen et al., 2004).

The Wraparound Model of Care

In order to address concerns that have been identified in uncoordinated systems caring for SED youth, Stroul and Friedman (1986) developed the wraparound model of care. The wraparound model of care is intentionally different from the fragmented delivery of traditional mental health and social services; it was created to address many of the barriers identified as impeding the successful treatment of SED youth and their families. Instead of removing youth from their families or providing piecemeal services to address a family's and child's deficits, this model of care emphasizes and values the involvement of the entire family in the treatment process, and focuses on the youth's and family's strengths in order to bolster treatment efficacy.

In wraparound, families are also given the opportunity to be the leaders of their treatment process, placing back in their hands much of the power that is taken away from them in traditional mental health treatments. Instead of leaving families to their own devices to coordinate multiple systems, wraparound services are team-driven, and facilitate collaboration not only between the SED youth and family, but also between the family and the multiple agencies that are involved, serving to streamline and coordinate treatment (Dulcan, 2010). A specific section within the U.S. Department of Education's 1998 Twentieth Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act entitled "Students with Emotional Disturbance" outlined strategies that would be important to uphold when serving this population. Within their recommendations, the national agenda emphasized the importance of families as partners in the planning process, as their contributions and valuable

knowledge about their unique family system could serve to enhance the services. The agenda also affirmed the importance of helping children to develop in the comfort of their own homes, schools, and communities. A reciprocal relationship was noted between family support and the success of placing children in least restrictive environments, whereby families who felt supported by the overall process were placed in decreasingly restrictive environments (Osher, Quinn, & Hanley, 2002). Consequently, the wraparound model of care has been proven to be more effective than traditional mental health services for this population.

When comparing wraparound services with traditional child welfare case management, Mears, Yaffe, and Harris (2009) found that wraparound services resulted in a decreased level of impairment and improved functioning. Additionally, according to a qualitative study seeking to understand caregivers' perspectives on wraparound services, Breault, Lewis, and Taub (2005) discovered that caregivers felt in control and supported. Additionally, they appreciated the wraparound model's strengths-based treatment approach. According to one caregiver, "I run the meetings, suggest the changes, and they make it happen." Another caregiver expressed their gratitude for the support she received, and stated, "They are there to help in every sense of the word" (Breault et al., 2005, p. 2).

The wraparound model values a strengths-based approach, where services are provided and built upon a foundation of the child and family's assets. Supporters of strength-based assessments posit that all SED youth have special gifts and abilities, which can be channeled into various treatment mechanisms. By acknowledging these strengths, children and families will likely feel more respected, engaged in treatment, and motivated to be more fully invested in the process (Cox, 2006).

Wraparound makes use of many of the concepts within positive psychology, which was

developed in response to a reliance on the disease model by psychiatric practitioners. This new model sought to acknowledge the positive and negative aspects of each client in a more balanced manner (Simmons & Lehmann, 2013). Positive psychology facilitates the incorporation of a client's positive characteristics and strengths into treatment just as much or more than a person's symptoms. A strengths-based, positive psychology approach serves to amplify a person's resources, capabilities, support systems, and motivations. This approach does not disregard a person's more troubling symptoms, but instead uses other aspects of a person to move them towards wellbeing and health (Simmons & Lehmann, 2013). Practitioners of positive psychology assume that by expanding on client strengths, they will experience their lives as more satisfying and fulfilling. Additionally, Rashid (2015) asserts that this approach has the potential to buffer against a recurrence of psychological issues.

Once the wraparound team is formed, intervention plans engage multiple agencies, community organizations, and informal community-based services as needed in a collaborative effort. Coordinators of the best wraparound services are particularly interested in tailoring unique intervention approaches, as every family system is likely to have distinct needs and desires (Dulcan, 2010). Strengths-based, family-centered, collaborative treatment approaches that occur in the least restrictive environment allow for the wraparound model of care to best serve SED youth and their families.

Assessment Tools Used by Wraparound Coordinators

Client report feedback measures such as the SRS (Session Rating Scale) and the ORS (Outcome Rating Scale; Johnson, Miller & Duncan, 2000; Miller & Duncan, 2000) serve to amplify clients' perspectives and voices. The ORS is a brief outcome measure that was developed as a time-conscious, easy to complete alternative to the Outcome Questionnaire 45.2.

The ORS contains four questions, and asks patients to describe their sense of their well-being, their relationships, their social life, and their overall progress in treatment (Miller, Duncan, Brown, Sparks, & Claud, 2003). The SRS was developed as a clinical tool that could be used by psychotherapists who were interested in tracking their therapeutic alliance with their clients. It contains five questions that are intended to assess the effectiveness of each session, and asks individuals receiving treatment to endorse their sense of how much they felt heard and understood, how much they felt as if the session focused on the necessary topics, the way work was completed between therapist and patient, the extent to which the session made sense and fit with the patient's needs, and their overall feelings about the session (Duncan et al., 2003). Although the ORS and the SRS have not yet been used in the context of wraparound care, they are very consistent with the overarching values of the model, and could help to strengthen the approach.

In the wraparound model, instead of diagnoses solely guiding the treatment process, families' views and opinions are viewed as equally important; client perspectives are considered meaningful indicators of outcome. Placing more emphasis on clients' voices by administering and discussing the results of such measures provides clients with control, and allows them to have increased authority over their own treatment process through providing feedback about it (Sparks & Muro, 2009). When case managers use measures like the SRS and ORS, they can obtain reliable information about the family's perspectives on treatment efficacy; this strategy is consistent with the wraparound emphasis on family-centered treatment.

Utilizing session and outcome feedback has been proven to be beneficial for all clients and, notably, has been found to be especially helpful for those clients who are initially projected to have a limited amount of success in treatment (Duncan et al., 2003). Increased client

engagement has also been proven to be a strong indicator of positive outcomes (Sparks & Muro, 2009). The wraparound model's mission of engagement and empowerment of families may be well served by the utilization of the SRS and the ORS.

The SRS and the ORS also offer many benefits to providers: The brevity of these measures allows coordinators the opportunity to use them after every session if desired; the measures allow for a transparent discussion to take place regarding the feedback that the clients are providing; and the measures are atheoretical; they can therefore be incorporated into any model of practice—including wraparound (Duncan et al., 2003). The ORS and SRS might further help providers to better understand their own impact, and the degree to which the wraparound model is functioning successfully for each individual family member, and the family as a whole.

Fidelity measures, which assess whether services are consistent with the goals of wraparound, can be another crucial assessment tool. Fidelity measures are described as "an essential, yet underemployed component of health and mental health service delivery and research" (Bruns, Burchard, Suter, Leverentz-Brady, & Force, 2004). Maintaining fidelity has been identified as crucial to gaining positive outcomes within children's behavioral health services (Pullmann, Bruns, & Sather, 2013), and fidelity measures such as the Wraparound Fidelity Index (WFI-EZ) were developed in order to assess providers' adherence to implementing the 10 essential components of wraparound (Bruns et al., 2004). The WFI-EZ evaluates all ten components including: family voice and choice, team based, natural supports, collaboration, community based, culturally competent, individualized, strengths based, unconditional, outcomes based. High levels of fidelity have been found to be indicative of better outcomes for youth receiving wraparound services (Effland, Walton, & McIntyre, 2011), and

therefore indicate that strengths-based treatment that adheres to these 10 components leads to better outcomes overall.

Measuring Alliance, Outcome, and Fidelity in a Wraparound Model

No research has been conducted exploring the impact of measuring alliance and outcome with the use of the SRS and ORS, on youth and families being served in a wraparound context. Filling this research gap has the potential to inform treatment providers and to help them to better understand the connection between key components of the wraparound model and brief session and outcome rating scores. It will be helpful to understand the type of impact the SRS and ORS have on SED youth and their families, and determine if these measures serve to further enhance some of the principles that the wraparound model strives to uphold.

Research Questions

1. Are scores on the SRS positively associated with outcomes on the ORS?
2. Are scores on the SRS positively associated with other fidelity measures being used by wraparound coordinators?
3. What effect does the SRS have on the way in which wraparound providers conduct sessions with SED youth and families?

Method

Participants

This study utilized archival data and qualitative interviews collected from three wraparound coordinators and one wraparound coach. I examined the closed case files of 44 families. Forty-three of these families identified as non-Hispanic, and one family identified as Puerto-Rican. Thirty-nine families identified as Caucasian, three families identified as African American, one family identified as American Indian, and one family identified as two or more

races. The identified youth receiving services under the wraparound program in New England, within each family, included 22 youth identifying as female, 21 youth identifying as male, and one youth identifying as transgender. At the time of data analysis, the mean age of the youth participating in the project was 13.58 years old. All families had participated in the wraparound program.

This project was initiated by a state in New England under a grant funded by SAMHSA, and sought to create an infrastructure that could help coordinate publicly funded child-serving systems, and better support the youth and families being served by these systems. The wraparound program served a small number of families through a newly created Care Management Entity, with the intention of ultimately expanding these services to treat increasing numbers of youth and families. The families who participated in this project were required to have a child ranging in age from 6 to 21 years who met the criteria for an SED diagnosis, and were at risk for immediate placement in a psychiatric hospital, residential facility, or secure correctional facility. In addition, at the time of referral, the family needed to be involved with two or more service delivery systems.

In addition to quantitative data collected from these families, qualitative data were also collected through individual interviews from the three Caucasian wraparound coordinators involved in the project: two females and one male. Additionally, an interview was conducted with the wraparound coach involved in the project, who is a Caucasian female. This sample of interview participants can be considered a convenience sample, as subjects were selected based on their accessibility and proximity to the researcher, as well as their participation in the wraparound program in which other data were collected (Mertens, 2014).

Instrumentation

In order to answer the research questions outlined above, archival data collected from three measures were used in this study. The Outcome Rating Scale (ORS; Miller & Duncan, 2000) helps the coordinator to understand how the family (including both caregivers' and youths' responses) perceives the child's progress from week to week. This measure was developed as a more concise version of the Outcome Questionnaire 45.2 (Lambert, 2004); its authors sought to reduce the length of time needed to complete such a measure, and increase its simplicity. In a sample of 521 participants including both clinical and nonclinical populations, concurrent validity of the ORS with the OQ is supported by a correlation between their total scores of .59. Test-retest reliability was estimated through the correlation of test scores at the first administration with each of the three subsequent administrations, and was significantly lower for the ORS (.49–.66) than for the OQ, (.74–.83). It is important to note, however, that the constructs assessed by these instruments might well be expected to evolve over time, particularly in a treatment context: Improvement is the goal of treatment, and will be variously attainable across participants, reducing test-retest "reliability" (Miller et al., 2003). Internal consistency reliability of this measure was explored with a nonclinical sample of 86 participants, revealing high internal consistency (Cronbach's alpha = .93; Miller et al., 2003). The use of this instrument in allowed for measurement of each family's perception of their child's progress over time.

The ORS contains questions such as "How have you been doing in terms of your personal well-being, from 0 (very bad) to 10 (very good)?" and asks parents and children each to rate their impressions on that scale from 0 to 10 (see Appendix C for the entire measure and response form). This measure was adapted for the purposes of this project, and was referred to as the Youth Progress Scale. The Youth Progress Scale's original wording was adapted in order to

account for the context in which it was being used. In order to account for change over time, initial ORS scores were used in conjunction with the last ORS scores for each family. If either of these administration times were not available (i.e., not administered to families), the administrations closest to the first, and closest to the last, were used in their place. The caregiver perspective was selected for this research study, as there were more data available from the caregivers' perspectives than there were from youths' perspectives.

The Session Rating Scale (SRS; Johnson et al., 2000) is a family-completed rating of the wraparound sessions that evaluates information including: if the family felt heard and understood, if the session addressed relevant issues, and if the session felt collaborative in nature. This measure was developed to provide clinical staff with insight into the therapeutic alliance occurring within sessions. In a sample of 420 paired administrations for 70 subjects, concurrent validity of the SRS with the Revised Helping Alliance Questionnaire (HAQ-II — a popular measure of alliance) is supported by a low to moderate correlation between their total scores of .48, indicating that the SRS is measuring some of the same constructs as this other similar measure in a more concise manner. Test-retest and internal consistency reliability were evaluated using a sample of 70 participants. Test- retest reliability was estimated through the correlation of test scores at each of six administrations except the last, with the score from the previous administration and was .64, indicating a moderate level of reliability. Coefficient alpha for all administrations is reported by the publisher to be .88, indicating a high level of consistency.

The use of this instrument in the study allowed for brief assessment of alliance between wraparound coordinator and family members (Duncan et al., 2003). The SRS contains questions such as, "On a scale of 0 to 10, to what degree did you feel heard and understood today, 10 being completely, and 0 being not at all?" and asks parents and children to rate their impressions on

that scale from 0 to 10. (See Appendix D for the entire measure and response form.) This measure was adapted for the purposes of this project and was referred to as the Team Meeting Rating Scale. The Team Meeting Rating Scale's original wording was adapted in order to account for the context in which it was being used. In order to account for change over time, initial SRS scores were used in conjunction with the last SRS scores for each family. If either of these administration times were not available (i.e., not administered to families), the administrations closest to the first, and closest to the last, were used in their place. The caregiver perspective was selected for this research study, as there were more data available from the caregivers' perspectives than there were from youths' perspectives.

Each family participating in the wraparound program in New England also completed a fidelity measure called the Wraparound Fidelity Index Short Form (WFI-EZ), where they were asked to rate a series of statements by checking off one of five categories ranging from strongly agree to strongly disagree. The WFI-EZ contains questions such as, "our wraparound team's decisions are based on input from me and my family" from the parent form, and "at every meeting, our team celebrates at least one success or positive event" from the child form. The Wraparound Fidelity Index Short Form (Wraparound Evaluation and Research Team, 2010) has been widely used to measure the fidelity of wraparound implementation from the perspective of the family. In order to investigate criterion-related validity, data were obtained from eight different sites where both the WFI as well as a Team Observation Measure (TOM) were administered. The Team Observation Measure is a structured observation protocol used in wraparound team meetings in order to assess for program fidelity. Raters score the meetings based on the presence or absence of 71 indicators (Wraparound Evaluation and Research Team, 2006). Local evaluators who were trained in the administration of each measure collected the

data, and a Pearson's correlation was conducted and demonstrated a significant association between the two measures (Pearson's correlation = .857; Wraparound Evaluation and Research Team, 2006).

The strong correlation between the TOM and the WFI-EZ should be considered an indicator of validity due to each measure's emphasis on issues of fidelity. The criterion related validity was established at .86, indicating a robust level of validity. The test-retest reliability coefficient for this instrument has not yet been established; however, the previous version's (WFI-3) test-retest reliability ranged from .64 to .88, indicating a moderate to high level of reliability. Coefficient alpha is reported by the publisher to range from .83 to .92, indicating a high level of internal consistency. The use of this instrument in this study allowed for an understanding of team members' opinions of the wraparound process as a whole, and the meetings' fidelity to wraparound's key goals (Wraparound Fidelity Index, 2010).

In order to answer my final research question, I conducted semi-structured interviews with the three wraparound coordinators and the one wraparound coach. Using qualitative procedures, I asked four basic questions (see Appendix E and Appendix F for these question sets). Through the semi-structured interviews, I sought to understand if the use of the SRS had influenced the coordinator's practice, and if so, how the use of this measure had guided the coordinator's interactions with families.

Procedure

In order to answer the two quantitative research questions, I used archival data from a wraparound program that took place in New England. To answer my third qualitative research question, I conducted semi-structured interviews with the three wraparound coordinators and the one wraparound coach.

The ORS was administered at the beginning of all family and home meetings in order to gain an understanding of the family's view of the youth's progress, and the SRS was administered toward the end of all team meetings in order to help coordinators understand how the process and goals of the meeting were perceived. Neither of these measures was administered more than once per week. During the session, wraparound coordinators read verbal protocols to the parents and child for each measure, and then asked family members to respond to these two brief verbal protocols on response forms containing Likert scales ranging from 0 to 10 for each question (see Appendices C and D for SRS/ORS verbal protocols and response forms). Once the family completed each measure, the coordinator was able to score them, use them to elicit open conversations, and track each family's progress over time. Although the intention was for these measures to be administered to both youth and caregivers, youth versions of the ORS and SRS were ultimately administered much less frequently than the caregiver versions. As a result, I chose to use the caregiver versions of these measures in this study, due to their increased availability in the data set.

The WFI-EZ was administered once for every family at one out of five possible sampling date schedules. The five potential sampling schedules are: start date + 2 months, start date + 3 months, start date + 4 months, start date + 5 months, and start date + 6 months. Scores from this measure were used as a measure of fidelity, and informed me of the extent to which the wraparound program in New England adhered to wraparound's core components. The WFI-EZ surveyed multiple perspectives, including guardian, facilitator, and team member. Although different terminology is being used for different measures, the "caregiver" perspective on both the SRS and ORS and the "guardian" perspective on the WFI-EZ were both completed by the same individuals within each team. Caregivers/guardians were the individuals within each team

who were responsible for looking after the youth, and who were legally responsible for them.

In addition to the use of these three measures, each of the three wraparound coordinators as well as the wraparound coach involved in the grant participated in semi-structured interviews. Before each interview took place, each coordinator was provided with an informed consent form (see Appendix B), where they were informed about the study and about their rights as participants. Once this form was signed, they were asked to answer a series of questions regarding their experience with using the SRS (see Appendix E and Appendix F for question sets). Interviews with the three wraparound coordinators and one wraparound coach elicited qualitative data, and informed me of the depth of their experiences.

Interpretive phenomenological analysis. In order to answer the third research question, an interpretive phenomenological method was employed, and an emphasis was placed on each coordinator's and coach's individual experience, perception, and the meanings they made of fulfilling their roles. Predetermined semi-structured interviews were used (see Appendix E and Appendix F), and the coordinators' and coach's responses were recorded for later analysis in a chart according to IPA methodology (see Appendix A, Tables 3–6). Through the interview, I sought to understand the coordinators' and coach's perceptions of using the SRS during team meetings (Smith, 2008).

Interpretive Phenomenological Analysis (IPA) allows for trends to emerge as a result of the semi-structured interviews that were conducted (Bloomberg & Volpe, 2008). The goal of IPA is to focus on a person's experience or understanding of a particular phenomenon or experience. Questions used in this type of research approach must be directed towards the meaning that is made and understood by participants (Smith, Flowers, & Larkin, 2009). This methodology assisted me in coming to conclusions about the commonality of a specific

experience, and, through IPA, to understand how participants made sense using these measures as part of their participation in the wraparound program in New England (Bloomberg & Volpe, 2008). It is important to note that participants were interviewed in their professional roles and asked for their expert opinions about the experience of administering and using feedback measures within the wraparound program in New England.

Sample size and participant identification. IPA does not identify a sample size requirement, and instead acknowledges the fact that many factors could influence the acquisition of participants, including organizational constraints. Instead of sample size, IPA is more concerned with eliciting detailed, rich accounts (Smith et al., 2009). IPA does recommend a homogeneous sampling pool, where all participants are members of a closely identified group (Bloomberg & Volpe, 2008). According to IPA principles, samples of participants should be selected intentionally, as this type of a sample can offer increasing insight into a specific experience. Participants are selected with the assumption that they will be able to help the researcher to understand their perspective on a particular phenomenon. This approach allows for the examination of differences and similarities in understanding of a particular situation. Potential participants can be recruited through referrals from various sources, opportunities as a result of the researcher's contacts, or referrals from participants, which is also known as snowballing (Smith et al., 2009). In this case, participants were recruited through the opportunities method, where I interviewed the three wraparound facilitators and the one coach who were a part of the wraparound program in New England. These participants were contacted via e-mail about the opportunity to participate in this research study, and agreed to participate.

Data collection. IPA allows for rich first person accounts as a result of interviewing. Rich data is acquired by allowing each participant interviewed to fully tell their stories, and to

speak freely and reflectively as a way to develop their own insights. Semi-structured, one-on-one interviews are the preferred manner of collecting this data, as this allows for the alteration and clarification of questions that are asked. IPA interviews allow for the participants to do most of the talking, while the interviewer brings up topics that allow for the research questions to be answered (Smith et al., 2009). Interviews lasted for approximately 20 minutes each, and focused on promoting a discussion where research questions were answered, and room was left for unexpected topics to emerge and be explored. Therefore, the information gathered and the discussion that ensued were more important than the order of the questions answered and the consistency of the way the questions were asked. The process of exploration encourages each participant to take some ownership over the interview process.

Throughout the interview, I was interested in understanding how the participants made sense of their world, leading to a double hermeneutic (Bloomberg & Volpe, 2008; Smith, 2008). The use of open questions, prompting, and probing were used to help each participant to answer each question or respond to each comment as fully as possible. In addition, establishing rapport, encouraging the participant to speak freely, and avoiding interrupting the participant are all key strategies that I used to ensure that each participant had the opportunity to answer respond the way they wished to. I provided each participant with an idea about the style of the interview by describing the general idea behind the questions verbally in the beginning of the interview. Interviews took place over the phone, fostering a comfortable setting for participants that allowed for few distractions. The interviews were conducted with professionals who are familiar with this topic and who were capable of easily understanding the intentions behind my study. Therefore, it was not likely that they felt threatened or upset by the process (Smith et al., 2009). All interviews were tape-recorded following the verbal permission of participants, which ensured

that all details of the interview were collected. Recorded interviews were then transcribed (Bloomberg & Volpe, 2008; Smith, 2008). Before the second, third, and fourth interviews, I transcribed the previous one. I also reviewed with my dissertation chair the interview structure as well as the strategies used in the interview (Smith et al., 2009).

Analysis and writing. IPA first requires a verbatim record of the data collection event. This was accomplished with the use of an audio recording, where interviews were replayed and transcribed accurately. The analysis proceeds in six steps. Step 1 of this process then encourages the researcher to read and re-read the transcript, where the participant becomes the sole focus of the analysis. Some of my most powerful first impressions were also recorded at this point. Step 2 encourages initial noting, where I noted anything of interest including ways in which the participant discussed or understood the phenomena of focus. These impressions were recorded on an electronic copy of the transcript in the left-hand column, labeled "exploratory comments" (see Appendix A, Table 3). Three types of comments can be included within this section: (a) *Descriptive comments* describe the content of the transcript, and take it at face value; (b) *linguistic comments* attend to language use including pronouns, laughter, repetition, tone, and fluency; and (c) *conceptual comments* are the most interpretive, and attend to the participant's understanding of the issue at hand.

Step 3 focuses on emergent themes in the transcript. In Step 3, details were reduced, and concise statements about the importance of the comments became relevant. It is important to note that themes that were identified at this point in the process were influenced in part by my own interpretation efforts, as well as my unconscious bias. These themes were recorded in the right-hand column of the transcript, entitled "emergent themes." Step 4 encourages the researcher to make connections across themes, assisting the researcher in understanding how the

emergent themes fit together.

Quotes from the transcript that seemed relevant to the major categories of themes were also collected at this time. At this stage, not all themes must be included, and they can be grouped together in many ways. *Abstraction* involves putting themes together that appear to have something in common, and developing a new name for each particular group. *Subsumption* is similar to abstraction, but instead allows for an emergent theme itself to name a particular group of other emergent themes. I listed each grouping and constructed a chart with the emergent themes organized in this way. In Step 5, I began again, focusing on the next transcript, repeating Steps 1 through 4 (see Appendix A, Tables 4-6). According to IPA, each transcript should be treated as its own case, which allows for new and unique themes to emerge in the process.

Step 6 encourages the researcher to look for themes across cases. Over the course of the interviews, I attended to potential connections between cases, or ways in which one case may serve to illuminate something about a different case. As a result of this analytic process, I created a table of themes for all of the transcripts collectively, where all participants' perspectives are represented in an organized fashion (Smith et al., 2009). Subsumption was utilized, where I collectively organized themes from across interviews into categories, and used an emergent theme title as a way to label each group individually. In order to accomplish this, emerging themes were placed in a separate document and printed out. Each theme was cut out, making separate pieces of paper for each emerging theme among the four transcripts. Then, emerging themes were categorized, and specific themes within each of these categories were selected as the title for that theme category. These theme categories were then documented in a chart (Appendix A, Table 7), where theme titles are listed in the first row in bold font, and the contents of each of these categories are listed below their respective theme title. Themes were then

analyzed according to each of the main categories listed.

Themes were then converted into a narrative, where they were explored and discussed in greater detail. Results from this research were written about first as an overview, where the general ideas behind what was found were explained in a simplified manner. Next, each superordinate theme was then examined using evidence and excerpts from each participant as a way to better clarify that particular theme (Smith et al., 2009).

Ethics. Qualitative research requires researchers to reflect upon the effect of the research on its participants. First, and common to most research, the avoidance of harm to participants must be of primary concern. This involves both forming research questions that will not be distressing to participants, as well as monitoring the effect of the interview throughout the process. Additionally, the informed consent must not only touch on the data collection method, but it must also mention what will happen with the data once it is collected. In this case, the informed consent informed participants that this research would be published as a dissertation through Antioch University New England. The informed consent also mentioned who would have access to the raw data, which in this case would be myself as the researcher, as well as any assistants and supervisors I have.

It was also noted in the informed consent that anonymity and confidentiality would not be entirely possible as there were just three wraparound coordinators and one wraparound coach in this project. However, since the information being collected explored professional rather than personal themes, it is not likely that I elicited sensitive information, making the issue of limiting anonymity and confidentiality less of a concern. Further, quotes used in the results section were not linked to specific participants, and therefore anonymity was protected in this way.

Finally, participants were informed that they had the right to withdraw themselves from

the study up to a certain point. IPA recommends choosing a reasonable amount of time, either up to the point of data analysis, or a certain amount of time after the interview has been conducted, such as one month. In the case of this study, participants were told that they had the right to withdraw up to one month after their interview took place (Smith et al., 2009).

Meaningfulness Criteria

With 44 participating families in the quantitative portion of this study, statistical significance at the conventional alpha = .05 threshold would require effects of larger magnitude than we are likely to observe. Rather than rely on statistical significance to indicate "meaningfulness" of the results, I used observed effect size. Based on related research described below, I decided that any correlation exceeding Pearson's r = .30—generally understood to be the boundary between small and medium correlations (c.f. Cohen, 1992)—be regarded as meaningful. Because I maintained a low threshold for r, it was important for me to consider that the more statistical analyses I performed, the higher the likelihood is that I would make a Type I error. While this method of analysis suits my small sample size, it heightens the risk of declaring that something is statistically meaningful when it actually is not.

My rationale for using this strategy is in accord with previous relevant studies. For example, according to other outcome-related studies that have investigated the use of the SRS and the ORS in several therapeutic settings, statistically significant effect sizes ranging from .28 to .54 have been found. In a study investigating continuous feedback during individual therapy, statistically significant treatment gains were found with effect sizes of .49 and .54 (Reese, Norsworthy, & Rowlands, 2009). Within another study that explored client feedback in couple's therapy, feedback was found to be a significant and positive predictor of ORS scores, and the effect size was .50 (Anker, Duncan, & Sparks, 2009). Last, a study examining the effects of

client feedback during group psychotherapy found that the feedback condition demonstrated larger treatment gains, resulting in an effect size of .28 (Schuman, Slone, Reese, & Duncan, 2014).

Rosenthal (1996) describes an effect size as the degree to which a particular entity exists. He states that when statistical significance is not found, many researchers tend to believe that no further interpretation is necessary, and that what is being studied is ineffective or unimportant. Rosenthal urges researchers to instead interpret the meaning of the findings even if the results are technically not significant. While using non-statistical reasoning techniques, the context of the research can be considered, providing a deeper meaning of the findings. Rosenthal asserts that comparing strengths of associations could be appropriate, but judging results individually does not always lead to a useful and rich interpretation.

Therefore, for this study, I first looked for a Pearson's *r* that was equal to or greater than .30. This result alerted me to the fact that my findings were consistent with other studies that have investigated the same measures, and at this point I was able to interpret my findings as significant. I was not able to declare my findings as statistically significant when my study yielded a Pearson's *r* of less than .30. Instead, as Rosenthal (1996) suggests, I interpreted and further discussed the context from which this research came in order to make some meaning out of my otherwise insignificant findings.

Results

Results gathered from the three research questions—two quantitative and one qualitative—are described below. This study was conducted with a total of 44 families who participated in a wraparound program that took place in New England. Depending upon the research question, the sample size differed. In the case of the first research question, the number

of complete archival records containing SRS and ORS scores over time was limited to 28. In the case of the second research question, the number of each type of WFI-EZ data (Caregiver, Team Member, and Facilitator) for each family differed, therefore impacting the number of data sets that were analyzed within each category. Additionally, some families' records contained one (or more than one) of each type of WFI-EZ data, while others did not. For records that contained more than one of each type of WFI-EZ data (e.g., three Team Member WFI-EZ responses), the last (i.e., most recent) data point was used from each family's record in order to capture the widest available span of time.

The families who participated in the wraparound program were eligible to participate based on their ability to meet specific criteria. First, youth and families needed to be experiencing difficulties impacting their daily lives as a result of an SED categorization. Additionally, youth needed to be at risk of an out-of-home placement (e.g., residential treatment facility, psychiatric hospital, juvenile justice facility), and they needed to have no open DCYF (Division of Children, Youth, and Families) abuse or neglect cases, or CHINS (Children in Need of Services) cases. Families who participated in this program were all Medicaid eligible, indicating that they likely were of low socioeconomic status. Team members involved in the wraparound process involved staff including the coordinator, as well as Parent Peer Supports. In addition to these specific team members, teams contained a combination of service providers from other organizations (e.g., community mental health centers, schools), as well as family identified natural supports (e.g., family members, neighbors, coaches, religious leaders).

Are Caregivers' Perceptions of the Process of Wraparound Team Meetings Positively Associated with Their Perceptions of Improvements in Their Youth's Level of Functioning Over Time?

In order to answer the first research question, a two-tailed Pearson's correlation was conducted to determine the strength of the relationship between families' perceptions of the implementation of wraparound values in sessions (SRS score), and their perceptions of improvements in their youth's symptoms and functioning over time (ORS score). Results reveal a very weak (and statistically non-significant) correlation (r = -0.05, n = 28). Results did not approach statistical significance, and therefore no further statistical interpretation is warranted.

Prior to conducting statistical analyses, meaningfulness criteria were set forth given my smaller than desired sample size. In the case of this first research question, results did not approach the threshold of .30 that I would have considered meaningful.

Table 1

Pearson Correlation Between SRS and ORS Data Over Time

	Guardian SRS Change Over Time
Guardian ORS Change Over Time	$r = -0.05$ $p = 0.82$ $N = 28$

Are Caregivers' Perceptions of the Process of Wraparound Team Meetings Positively Associated with Their Perceptions of Their Team's Ability to Successfully Implement the Values of the Wraparound Model?

In order to answer the second research question, the last administration of the guardian SRS score was used in conjunction with various versions of the WFI-EZ (i.e., Caregiver, Team Member, and Facilitator). The last administration of the SRS was chosen due to the observation that SRS scores tended to increase over time for each family, likely due to the development of relationship between each family and their wraparound team. A two-tailed Pearson's correlation was conducted to assess the relationship between the last SRS score, and multiple versions (Facilitator, Caregiver, and Team Member) of the WFI-EZ to determine the strength of the relationship between two measures that seek to understand families' perceptions of the implementation of wraparound values within sessions. Results, depicted in Table 2 below, show very weak (.05 for correlation with Team Member WFI-EZ) to moderate (.36 for correlation with Caregiver WFI-EZ, and .36 for correlation with Facilitator WFI-EZ) relationships between the final indication of guardian perceptions of team meeting effectiveness and varying team members' perceptions of the team's ability to uphold wraparound values within each meeting

($r_{\text{Guardian SRS x Facilitator WFI\_EZ}} = .36$, p = .01, $r_{\text{Guardian SRS x Caregiver WFI\_EZ}} = .36$, p = .31, $r_{\text{Guardian SRS x Team Member WFI\_EZ}} = .05$, p = .84). Based on the meaningfulness criteria that I had identified (i.e., a threshold of .30 or above to consider data meaningful) given my smaller than desired sample size, I consider two out of the three computed correlations meaningful. Results indicate noteworthy correlations existed between facilitator and caregiver versions of the WFI-EZ and guardian SRS scores. This suggests that measures of wraparound fidelity (WFI-EZ) are in some way related to families' perspectives of the wraparound session process (SRS). These correlations could indicate that some of the same concepts being measured by the WFI-EZ in relation to fidelity to the model are also measured by the SRS.

Table 2

Pearson Correlations Between SRS Data and Multiple Versions of WFI-EZ

	Facilitator WFI-EZ	Caregiver WFI-EZ	Team Member WFI-EZ
Guardian SRS	$r = 0.36$	$r = 0.36$	$r = 0.05$
	$p = 0.01$	$p = 0.31$	$p = 0.84$
	$N = 23$	$N = 10$	$N = 23$

How Has the Use of the SRS Changed the Way in Which Wraparound Providers Conduct Sessions with the SED Youth and Families Involved?

Following the IPA analysis process, seven themes emerged as most relevant to the experiences of the coordinators and coach throughout their time participating in the wraparound program. These themes include: (a) team process, (b) strengths-focused approach, (c) family narrative, (d) role as coordinator, (e) administration of scale, (f) benefit of completing scale, and (g) drawbacks of administration. Each of these seven theme categories contains several related subthemes that serve to further elaborate and add to the picture of the overarching category. A chart containing emergent themes can be found in Appendix A, Table 7.

Themes

Below, each of the seven themes is explored in depth, and excerpts from interviews are included in order to provide a more complete understanding of each interviewee perspective.

Team process. One of the most prominent themes across all interviews was the coordinators' and coach's discussion of the team process itself, and how team meetings were conducted. Interviewees' discussion of this topic is consistent with the idea that the wraparound process requires coordinators to accomplish several tasks during team meetings. The theme of

Team Process had 24 subthemes, including:

1. coordinator approach to team meetings,
2. conversations within team,
3. coordinated effort,
4. non-judgmental stance,
5. team uniqueness,
6. focus on common goals,
7. unique process,
8. components of meeting,
9. collaboration,
10. coordination within community,
11. documentation,
12. purpose of meetings,
13. skillful approach,
14. complicated process,
15. making changes to team meetings,
16. differing feelings about meetings,
17. the art of the process,
18. family enjoyment of team,
19. ground rules,
20. pride in being part of team,
21. facilitating conversations,
22. structure,
23. improvement of team meetings, and
24. inclusion of team members.

As the main interview questions in this study were centered around the Session Rating Scale (SRS), respondents spoke about how this measure impacted their ability to successfully structure meetings over time. It appears that coordinators used this measure as a way to understand which types of process-oriented components should be considered during a wraparound meeting. For

example, one coordinator described:

> But, you know I think we grew over those few years and we got more comfortable with everything. I think that every team looks different, but an overall positive thing from that is that it helped to shape meetings, and helped facilitators to feel comfortable facilitating a meeting. It not only helped to guide families, but it helped to guide us as facilitators to know what was the meeting going to look like, you know, at its core. Even though it was different for every family. (Transcript 2)

In addition to providing some process-oriented structure to meetings, respondents discussed how the SRS impacted the way that team meetings were taking place over time. Respondents were not only using this measure to shape the structure of individual meetings, but they were also using it to help keep the team on track over the course of multiple meetings. Therefore, if the SRS was indicating that certain aspects of a meeting were not being adequately addressed, respondents were able to use this data in order to help the team to align more with the family's needs. For example, "Yes, making sure that we are on track as a team, and going in the right direction. Because if people are not feeling those things that are listed in the rating scale, then we are not on track" (Transcript 3).

Last, respondents agreed that using this measure informed a process by which the team could respond to the family members' stated needs given their responses on the SRS. In this way, team meetings were often adjusted and adapted, increasing the level of responsiveness between families and team members, and further fulfilling the ideals as outlined by the wraparound model of care.

> I would just approach it that, you know, the family's last meeting, whatever the specific thing was, I would just be open and honest with it. That we the team need to work harder

> at really making sure that everybody is feeling heard and understood and included, and that goes for all of the team members as well. Sometimes we will go back to our ground rules in the meeting, depending on what is off. That would indicate how he would use that to change or address any number of issues. (Transcript 3)

Overall, respondents seemed to agree that the SRS helped with several aspects of the team meetings that were held. Not only was this measure useful in guiding the way in which respondents conducted each team meeting, but the SRS also played an important role in assisting respondents in acknowledging the family's needs in order to make changes over time.

Strengths-focused approach. The second theme that emerged during interviews addressed the strengths-focused approach that respondents wove into their practice during team meetings. Four subthemes were identified as falling under this main category, including: positive experiences, successful parts of program, celebrate successes within the team, and positivity. Across interviews, respondents reported themes of family empowerment, as well as a focus on the positive aspects of families' efforts and lives. In particular, removing some of the blame and stigma that parents often experience when interacting with mental health systems, on behalf of their children, was one way that coordinators emphasized families' more positive qualities. One coordinator below further discusses this removal of blame and stigma:

> I: So it sounds like it kind of helped to remove some of the blame that parents sometimes feel when they are in a situation like this with their children.
>
> P: Yeah, and I think really helping give the family, especially the parents, more of that, you know, positive self-worth, and like that positive, like "Hey I can do this," and we are just in a bad spot, but we can, it really helped them to build their capacity.
>
> I: Right, and to kind of move forward and know that there are people who want to

> support them rather than criticize them. (Transcript 2)

In addition to attempting to decrease the amount of shame that families may have experienced, respondents shared their perspective on the importance of helping families to understand that their team was strong and capable of helping them. As a result, families appear to have been bolstered by the reinforcement that they received from wraparound coordinators about the team as an asset. One coordinator reported:

> Yeah, obviously we want progress and outcomes, but what really helps is for families to know that their team is strong and that they are supported. I think that's a huge accomplishment in general, something to celebrate. (Transcript 4)

Within this theme category, it appears that respondents felt strongly about emphasizing aspects of families' care that were more positive in nature, further upholding the wraparound model of care. This theme was relevant not only during times where coordinators were bolstering families' levels of agency, but were also relevant in the context of the team as a whole representing a strong support system capable of assisting each family effectively.

Family narrative. Respondents also felt strongly about placing an emphasis on each family's voice and personal preferences. Twenty-two subthemes were identified as falling under the main theme of family narrative, including:

1. family-centered approach,
2. respect of family choice,
3. personal process,
4. family uniqueness,
5. family voice,
6. family investment,
7. family overwhelmed,
8. families as individuals,

9. family capacity,
10. consideration of family needs,
11. level of enthusiasm,
12. facilitation of family collaboration,
13. individualized treatment planning,
14. acuity of population served,
15. youth voice,
16. incorporation into family plan,
17. family support,
18. family inclusion,
19. supporting the family,
20. removal of blame,
21. emphasis on family voice/feelings, and
22. collaboration

As each family presented with their own unique needs and wishes, respondents understood that each family's perspective was most important. Aside from gathering meaningful responses from the SRS, respondents also proposed that each family's narrative responses during team meetings were indicative of the team's level of success.

> I: So the next question I have is, how do you think that the inclusion of the SRS has affected wraparound session for coordinators based on their reports to you?
>
> P: Umm I think that they consider it and they want you know it to, the scale to show satisfaction and comfort with the process, but I think there is also a lot of other things that are important measures of how things are going.
>
> I: Like what?
>
> P: Like, what the family is saying, how they um, feel, it's hard to, it's more what the family is saying and what they are reporting in narrative as much as what they are putting on the form.

I: So it sounds like the more meaningful part is the actual interaction between the family and the coordinator?

P: Yes, definitely. (Transcript 1)

In addition to attending to families' narrative descriptors in order to evaluate progress and engagement, coordinators also took families' perspectives into account in other ways. This not only means that coordinators worked to hear what each family wished to be included in their plan of care, but it also meant that coordinators paid attention to and respected the components of treatment that were not desired. This exchange exemplifies "respect of family choice":

P: Oh, I have had people refuse to do it, they just say no, they didn't want to.

I: Oh, and you ever explore that more?

P: No. Because that really is not my role. And, of course, I tell them that they can think about it and if they want to come back to it later they can give me a text or call. And I just leave it there. And I think with youth, especially teens, without feeling forced, typically they will come around the next time. Sometimes they are just not in a good place or a good mood, and they do not want to be cooperative. And you know, there is a lot of especially with teenagers a lot of influencing coming at them about what they have to do. But I don't put myself in that position. I offered to them, let them know how I can be helpful, and if they don't want to do it they don't have to do it. (Transcript 3)

Respondents also felt that aside from parents' views about the progress of the team as a whole, it was also extremely important to hear from the youths themselves. Although several respondents felt that the youth version of the SRS was not always reliable with younger children; the general consensus confirmed that incorporating youths' perspectives into team meetings was valuable, and often revealed discrepancies within families. By including SRS data from youth, the family

narrative itself became stronger and more coherent. This addition also allowed for coordinators to strategize with the team about the effectiveness of meetings, considering the entire family narrative as essential to effective service delivery.

> P: Um, I think that some of the most positive is more so for youth voice. I feel like caregivers often feel pretty good because they understand the concept, I think what can get lost as when the youth is on the younger side. And the process is pretty complex for someone who is 6. I think these questions are easy enough for a 6 or 7-year-old, where if they're giving their rating that is like a 4, it just helps the coordinator to share with the team to say we really need to make this easier and more understandable for this youth. And kind of brainstorm in coaching about how we can make this experience better, so that they can voice how they are feeling I guess.
>
> I: And also, I bet, helping them to feel that they are included more.
>
> P: Right, exactly. I think that that is probably the most helpful, other than the stuff that I already said. I think that sometimes seeing a difference between the caregiver and the youth is really helpful too.
>
> I: Can you say more about that?
>
> P: Um, I don't know, I am a family therapist by nature so when I see a disconnect, I don't want to necessarily use the word disconnect.
>
> I: Like a discrepancy?
>
> P: Yes, say like dad rates a 9, and the kid is like a 4. I think that's just a good talking point to say we are seeing some real family dynamics around how things are being communicated and talked about. And just to see where the structure is different. (Transcript 4)

Fully understanding each family's narrative has proven to be essential for interview respondents. Through whichever mechanism this narrative is understood (e.g., through responses on the SRS, through families' statements during team meetings, through youths' reports), it is certain that families' perspectives were taken seriously, and were considered essential to successful team meetings.

Role as coordinator. Several interview respondents expressed their understanding of a wraparound coordinator's role. These ideas are further described by 15 subthemes, including:

1. service delivery,
2. longstanding experience,
3. experience,
4. levels of comfort,
5. feeling overwhelmed,
6. purpose of coaching session,
7. impact on coordinators,
8. value in coaching,
9. essential nature of coaching,
10. use of coaching,
11. transforming roles,
12. meaningful work,
13. role as coach,
14. need for resources, and
15. experienced clinician.

One account in particular summarized many of the respondents' views about what their role entailed, and how they embodied it in order to adequately meet both the needs of the family, as well as the requirements set forth by the wraparound process itself.

> Right. So we always talk about the art and the science. So the science is you know you have a step-by-step process. Not really step by step but a pretty structured process, and on

> the other hand you have to individualize it to families and use it, so that is the art. (Transcript 1)

This explanation of the process as a whole brings to light the complicated nature of the work that has been accomplished throughout the grant period. An understanding existed for almost all coordinators that there were certain aspects of the process (e.g., paperwork, scales, certain topics) that needed to be addressed in order for each family to progress. Respondents also described the need to artfully deliver all of these components in a way that was appropriate and felt comfortable for individual families.

Administration of scale. Although mostly consistent, respondents described the unique ways that the administration of the SRS was incorporated into team meetings. Within this category, 13 subthemes resulted, including:

1. alternative measure of progress,
2. small meaningful changes over time,
3. shifts in ratings,
4. score trends versus one-time ratings,
5. adherence/fidelity,
6. meaningfulness of small changes,
7. consistency of administration,
8. exposure of measure over time,
9. variability of ratings as a means to change,
10. therapeutic indicators,
11. perspectives on progress,
12. component of process, and
13. variability in ratings.

These subthemes not only included the logistical components (e.g., when the measure was completed, who completed it, how it was scored), but also took into account the way coordinators approached helping families to understand the purpose and utility of this measure.

> P: So, I used to, we used it every single team meeting that we did. I usually just set it up for the families that, first of all it was really easy, it was only four questions. So it only takes like 2 minutes to fill out so, it's really easy for families to complete. I kind of frame it that as it's just the way we are able to communicate how effectively the team is helping you, is helping the family. So I just frame it as for you to be able to be honest and open with feedback of how we are working for your family to meet those needs is really helpful. I would say I don't really exactly remember when, but we would incorporate the team meeting rating scale into our plan of care document. So right on the front of the plan of care there is an actual scale that shows the rating of the youth and the family every team meeting. If we start to see a trend, like it is going up or down, it is something to celebrate or talk about as a team if we need to improve somewhere. (Transcript 4)

Respondents' ability to explain the purpose of the SRS by emphasizing the ways it can assist in helping families to provide feedback to the team appeared to result in future discussions that could help teams to renegotiate their purpose, or to celebrate their success in working together favorably. Following the administration and tracking of SRS scores over time, it was the responsibility of coordinators to decide how to incorporate such results into the next team meeting. This demonstrates that the utility of the SRS did not end at the administration, but it was incorporated into team meetings in many other ways beyond the family's completion of the measure at the end of each team meeting.

> P: We typically, as the meeting comes to an end, we identify our next meeting time and then I will administer this scale to the family and youth, sometimes the team members are there, sometimes they're in the midst of leaving. So it just depends. So everyone on the teams are pretty used to it, so they know it's a part of the meeting and if they would like

> to talk to the family they typically kind of wait. And then if there is any huge change in that rating scale, I would bring that to next team meeting. Just to remind the team that we are all working towards this common goal, for whatever reason if something's off. And then it goes in the positive too, if the family is feeling much better, that's the reason to celebrate as a team. (Transcript 3)

In addition to respondents' ability to address changes in the SRS over time as a component of their practice, some respondents also commented on the way in which this measure was artfully incorporated into team meetings. Because the wraparound model itself requires a considerable amount of effort from coordinators and team members to accomplish many tasks during each meeting, some skill was required in order to accommodate all components, including the administration of the SRS.

> I: Okay. And what about, I know that there is a lot going on in each of these meetings. Does the SRS ever feel like a burden, or like something that is an extra step? Does it ever feel like the family thinks "just another piece of paper work"?
>
> P: It can feel that way. It typically depends on the meeting. But I think if you do it initially and make sure that you get into the habit, the family becomes accustomed to doing it. So I don't feel that they look at it as a burden, it's just part of the process. Like I said sometimes is not appropriate. So just keeping in mind, who I'm doing it for and the purpose of it. Is it for me for my paperwork and documentation? As a check off? Or is it for the family? And if it is for the family, then I have to do it at the appropriate time. (Transcript 3)

Respondents identified different components of the administration of the SRS as relevant to the process as a whole. Coordinators felt as if the appropriateness of administration was important,

as each family's best interest had to be considered in the process. This often meant that scales were not completed on some occasions due to a family's emotional state or circumstances. Additionally, respondents felt that orienting families to the purpose of the measure assisted in uniting the team towards a common goal. Respondents acknowledged that the SRS had to be integrated into each meeting in a way that did not contribute additional pressure on the requirements of the meeting that were already being placed on members of the team. The point at which the SRS was administered during each meeting proved to be only part of the larger contribution that the SRS made to meetings, as the responses gathered from these scales proved to facilitate meaningful conversations between team members about the process.

Benefit of completing scale. Respondents described several benefits in using the SRS within the context of team meetings. Within this theme category, 28 subthemes emerged, including

1. utility of scale,
2. natural tool,
3. feedback,
4. indicator of meeting progress,
5. natural implementation,
6. minimal confrontation,
7. honesty,
8. responsibility,
9. improve approach,
10. meaning of success,
11. measure as a guide for meeting,
12. scale facilitating conversations,
13. ease of use,
14. evaluation of process,
15. informing future meetings,

16. therapeutic alliance,
17. scale informing process,
18. responsibility,
19. simplicity,
20. measure of success,
21. openness and honesty,
22. understanding the purpose,
23. rating scale indicators,
24. avenue for change,
25. feedback discussion,
26. measure of treatment considerations,
27. structure, and
28. skillful approach.

Respondents spoke about components of this measure that proved to be especially helpful or beneficial to families or to the team as a whole. Specifically, some respondents felt as if this measure allowed for caregivers and other family members to assume control over the process. Using the SRS allowed them to build upon their own feelings of competency in a situation that could potentially feel overpowering from the perspective of the family.

> P: Yeah, I think, and I know we spoke a lot with [the evaluators] about this, I think the team meeting rating scale was much more natural to implement with families than the ORS was. I think it was because of not only the environment we were in, but, yeah it just felt more natural because when we were doing the ORS, we would walk into some situations that you can't plan for and to have a family, you know, fill out a questionnaire wasn't always appropriate. But with the Team Meeting Rating Scale, I saw two things. I saw that it was really helpful for most families, where they were able to kind of share and feel that they could be honest with the team members about how the meetings were

> going. It kind of helped to build that sense of caregiver capacity that we were really trying to promote through the program. (Transcript 2)

In addition to helping families to feel that their voice was valued throughout the process, administering the SRS also assisted coordinators in communicating with families about their feedback in a safe and constructive manner. Not only did respondents feel comfortable with addressing potential discrepancies or changes that they observed between SRS administrations or versions, but they also used the SRS as a way to build alliances with families by communicating to them that their opinions were heard, and that they mattered.

> P: Um, I think that the SRS, since it was such a natural scale to use, it really helped, um, I think the way I explained it to families was that from them completing this, it really helped to prepare for the next meeting, prepare for future meetings with providers because it was really their voice, to tell us how things were going. And I would use that to have that conversation with a family. It was a nice way to kind of start that conversation, like 'Oh, hey, I looked at your scores from the other day and I saw that you rated this meeting a little bit lower than last time, you know, what was different, what could we do better as a team, you know, what would you like to see in the future?' So really starting to help the families to kind of um, I had a few families who kind of felt that they wanted these quick fixes, and the wrap meetings, it's a slow process. So a lot of times families, especially caregivers would be really frustrated, in their minds they would, it was hard for them to see much success. So this tool was a nice way to say to them "I understand where you are coming from, I see the rating scale is lower, so what can we do during the next meeting, what can we talk about, or, how can we structure this so that you feel that we are making better progress. (Transcript 2)

Pragmatically speaking, respondents also identified the ease of use that the SRS offered. Respondents felt as if administration was very simple, and that it was a satisfactory way to measure and navigate the team process and alliance.

> P: Yeah, any session I think. Because it is so quick and easy to use, and it is a good way to gauge, even if it is just writing on paper, and folding it up, and looking at it. Even if the therapist looks at it afterwards, I think it's helpful to direct the relationship. I am getting a little bit more soap-boxy but I think for our practice that's really cool. It's a nice tool, and it's really easy to use. (Transcript 4)

Respondents expressed an overall level of satisfaction with the SRS's ability to assist families in gaining some level of control over the process, to promote conversations about feedback and the process as a whole, and to provide a simple way to gain an understanding of families' perspectives on the team process.

Drawbacks of administration. In addition to the positive aspects of administering and making use of the SRS, respondents also identified 13 areas of concern with using this measure. These 13 subthemes include (a) age of youth, (b) honesty, (c) unimportance of scale, (d) family honesty, (e) variability in ratings, (f) dislike of high ratings, (g) inaccuracy of ratings, (h) refusal to complete form, (i) scores taken personally, (j) family hopefulness, (k) accuracy of measure, (l) appropriate timing of administration, and (m) burden.

First, respondents discussed the requirements of the wraparound model, causing them to have to include many elements within each team meeting. This in turn made some requirements such as the SRS feel like less of a valuable component and more of a burden.

> P: I think that the problem is, when they are doing team meetings, there is so much to include and so much to get done in a short period of time, that sometimes it would feel

> like a burden to have to do it at the end. I think they got on a roll with it, but at the beginning it was like oh my goodness, I have to get all of this done and I have to do this scale. (Transcript 1)

Also related to the high level of requirements placed on coordinators and team members alike, some respondents felt as if families became apathetic to the wraparound process, including the administration of the SRS. In this case, it is possible that the meaning behind the use of the SRS was regarded as less important as the meetings progressed over time. For example:

> P: I think it was at that point, it was just like, 'okay,' there wasn't as much excitement anymore of like 'yeah let me tell you how I feel.' It was more of just like 'okay let's just get this over with.'
>
> I: Yeah, so, what you had talked about before about it being valuable to help you set up future sessions more successfully, they kind of were no longer invested in that part of it.
>
> P: Mmhmm, right. And I found that in some meetings, some families were so busy that they were squeezing us in, so of course, they were involved in other things. Part of it is, how do you know when a family is ready to transition and all of that. But you know, some families we would have a meeting from 9:00 to 10:00 at the school, and then mom had to rush to work. So sometimes there just wasn't that time.
>
> I: To sit down and think about this extra thing.
>
> P: Right, yeah. (Transcript 2)

Another concern that respondents had about the use of the SRS was the degree to which it was appropriate to administer it at a particular time. These meetings often addressed issues that carried emotional charge; the family members felt unhappy, upset, or angry throughout the hour. As a result, respondents sometimes felt as if administering the SRS to distressed participants at

the end of meetings was not fitting.

> P: Umm, my experience using it, has been overall good. There are occasions when it's not appropriate. Sometimes team meetings don't go as you would have planned, and people can become tearful and that would not be the appropriate time to pull that out. However for the most part, it is good. (Transcript 3)

Respondents also questioned the ability of the SRS to accurately capture the data that it was intended to capture. The SRS required families to provide feedback to the team as a whole about the extent to which they felt that the team had been responsive to their needs on a particular meeting day. This had the potential of bringing about some level of bias, as respondents believed that family members could potentially have felt pressured to provide certain ratings in order to satisfy the team members who would be reviewing this feedback.

> P: In a way that it can be not useful, is a lot of times I think that families may feel badly about scoring it a certain way, that they don't want to hurt anyone's feelings. In that case, I find it to be not useful. Because, they're not being honest. And I just try to remind them that this is about the team as a whole, it’s not about any specific person, it is about a feeling and not a fact. I just try to remind them of those things and certainly no one would take any offense if they felt not good about a meeting, it's just used to help us in the future. Sometimes I find, especially with young kids, they really want to please you, you know, so I don't know if it's always accurate. However, over a long period of time, typically will find some kind of, where it ebbed and flowed a little bit. And the difference between the changes might be very small, but small changes can be meaningful. (Transcript 3)

Related to concerns about the accuracy of scores on the SRS, one respondent in particular

discussed the difficulties they experienced with receiving high scores on the SRS from the outset. When this occurred, it became challenging for this respondent in particular to feel as if they could affect meaningful change that would be reflected in the ratings on the SRS. In addition, it seems from the coordinator's perspective that obtaining such high scores at the outset of treatment made them question the openness of respondents; it did not seem possible that teams could be earning such high scores during their initial meetings.

> P: What's hard for me the most is when, from the get go I am getting 9's or 10's. To me, that's great, and that is something to celebrate. But for the first team meeting to maybe towards transition if I've gotten all 10's it just, to me, I don't want to say that it's negative, but I don't feel like it's necessarily used the way it could be used.
>
> I: Right, because if you are getting a 9 or a 10 on the first session, it is almost like where do we go from here if everything is already almost perfect.
>
> P: Right, and you could chalk it up to the team meeting is really good from the get go, but it makes me wonder that's all. It's not negative necessarily but...
>
> I: But it sounds like that is a difficult point to get past when you are the one being perceived as amazing on the first session.
>
> P: It just makes me wonder if the coordinators are the person who should be administering them. Some families are really honest, and some have a tough time. (Transcript 4)

Although it seems that the benefits of using the SRS outweigh the drawbacks, respondents were able to offer several examples of occasions where they questioned some component of this measure. Specifically, respondents felt that the significant requirements placed upon them made it difficult for families to feel particularly excited or enthusiastic about completing the SRS over

time. This could also indicate that the meaningfulness of using the SRS was lost over time for some families. Family distress and big wraparound agendas further made it difficult to administer the SRS every time. Additionally, respondents questioned the accuracy of the SRS scores, based on the assumption that families likely responded to the measure by providing ratings that were not consistent with how they actually felt.

Discussion

This study's purpose was to understand the utility of session and outcome-rating scales in the context of one particular New England wraparound initiative. In order to better understand the system as a whole, as well as the contribution that particular rating scales made to this process, three research questions were proposed. First, I determined the extent of the correlation between families' perceptions of their working alliance with wraparound coordinators, and families' perceptions of their child's outcome. Second, I established correlations between families' perceptions of their working alliance with wraparound coordinators and observer-rated fidelity to the wraparound model. Last, I sought to understand wraparound coordinators' perceptions and responses to the use of a measure of alliance with several qualitative research questions. In order to answer these three questions, both quantitative and qualitative analysis methods were employed. The following remarks intended to examine these three research questions, one at a time, in order to elaborate more fully on the results of my analyses. I also offer explanations about what the results of this study may mean, both in the context of this particular program, and beyond.

Are Caregivers' Perceptions of the Process of Wraparound Team Meetings Positively Associated with Their Perceptions of Improvements in Their Youth's Level of Functioning Over Time?

Results from my first research question suggested that statistically, there was not a meaningful relationship between families' ratings on the Session Rating Scale (SRS), and their ratings on the Outcome Rating Scale (ORS) over time. Prior to conducting this analysis, I had made the prediction that families' perceptions of the process of team meetings, including their alliance with the wraparound coordinator (as measured by the SRS), could be predictive of their perceptions of their youth's progress over time (as measured by the ORS). Research suggests that using session and outcome feedback mechanisms are beneficial for all recipients of mental health treatment, and are especially helpful for those recipients who are initially projected to have less success in treatment (Duncan, 2003). Furthermore, research suggests that clients who are increasingly engaged in mental health treatment tend to have better outcomes overall (Sparks & Muro, 2009). As a result of this information, I had predicted that increased family engagement as measured by the SRS would lead to increases in perceptions of youth outcomes, as measured by the ORS.

As a result of the non-significant findings, it becomes more important to consider the context from which the results emerged. In this case, it is possible that with a larger sample size and more complete data sets (i.e., data sets including all first and last administrations of each measure), these results could have yielded significant findings more consistent with the literature and expectations.

Additionally, examining the context from which this data came brings to light the notion that the wraparound process is somewhat imperfect: Team agendas tend to unfold

organically—for example, rearranging in a time of crisis—making it less likely that required questionnaire data are collected at each meeting. As the research suggests, youth and families being served by this project tended to be a higher-need population, containing youth with acute mental health related service needs. As a result, it is possible that the process by which data was collected was somewhat imperfect and less consistent than would be typical for a less acute population. This imperfect data collection indicates that team members were likely very dedicated to honoring the family's needs, which in this case could have meant that data did not always get collected at the required points in time. Some of the remarks made by wraparound coordinators about their dedication to serving each family's needs uniquely during each wraparound meeting could further explain the variation in availability of particular scores. Even independent of a crisis, coordinators often worked to determine and act on what was in the best interest of each family at the time, using their discretion to apply team resources more effectively during a given meeting.

Due to the weak nature of the correlation between SRS and ORS scores over time, it is also important to consider the possibility that these two measures would not have a meaningful relationship, even if the data set were more complete. If this were to be the case, families' perceptions of the process and alliance within team meetings would not necessarily be indicative of any information about families' perceptions of their youths' progress. For example, caregivers appear to have viewed the relationship with the team as very positive from the outset; however, they may have continued to see their children struggling despite the team's best efforts.

Are Caregivers' Perceptions of the Process of Wraparound Team Meetings Positively Associated with Their Perceptions of Their Team's Ability to Successfully Implement the Values of the Wraparound Model?

Results from my second research question demonstrated more meaningful findings. When scores on the SRS were examined in relation to scores on the team member version of the WFI-EZ, a weak correlation was found. However, when scores on the SRS were examined in relation to scores on the facilitator and caregiver versions of the WFI-EZ, moderate correlations were found, indicating that a meaningful connection existed between certain versions of the WFI-EZ and the SRS.

Preceding statistical analyses, I had predicted that a meaningful relationship existed between all versions of the WFI-EZ and the SRS. The WFI-EZ measures multiple components of fidelity within the wraparound implementation process (Wraparound Evaluation and Research Team, 2006), including team member satisfaction as well as experiences within wraparound meetings. The wraparound model of care is committed to providing family-centered, responsive care that emphasizes family strengths and empowerment in order to bolster treatment efficacy (Dulcan, 2010; Stroul & Friedman, 1986). These qualities are measured in the WFI-EZ, and it is possible that similar components are measured on the SRS, which is designed to better understand the therapeutic alliance and satisfaction between service provider and recipient (Duncan et al., 2003). I believed that it was therefore possible that the SRS measures some of the same concepts that the WFI-EZ did. As a result of this rationale, I had predicted that scores from the WFI-EZ and the SRS would be correlated in a meaningful way.

Results from this research question suggest a potential positive relationship, whereby scores obtained on the SRS may in some way inform scores on the WFI-EZ. This suggests that

the SRS captures some of the same information that the WFI-EZ intends to measure (e.g., adherence to the wraparound model of care, emphasis on family voice and perspective, alliance). Specifically, moderate correlations were found between the SRS and both facilitator and caregiver versions of the WFI-EZ. These results exceeded the threshold of .30 I had identified prior to statistical analysis. In both versions of the WFI-EZ, questions are asked about specific experiences that were present within the context of wraparound meetings, and information about youth outcomes. In the caregiver version of the WFI-EZ, an additional scale measures satisfaction with their overall experience. The team member version of the WFI-EZ, which was not meaningfully connected with the SRS, only measures experiences in the wraparound setting.

It is possible that the team member version did not have as strong of a connection with the SRS due to the team members' positions within each of their teams. Although still an important component of the process, it is likely that both families and facilitators were more fully involved in and aware of the process, causing them to pay more attention to the content and process of each meeting. Since team members could have been providing more of an outsider's perspective that was less personal in nature, it makes sense that this perspective did not have as strong of a connection with SRS scores. Additionally, the absence of the outcome scale on the team member version of the WFI-EZ could have impacted the strength of the correlation between SRS and team member WFI-EZ.

Generally speaking, results from this research question suggest that the SRS captures important components of team process, similar to the WFI-EZ. As has already been established in the research, the SRS provides useful information to service providers in a rapid manner in order to inform treatment moving forward. From the results of this study, it seems that the SRS can also play a useful role in the wraparound context and that positive outcomes for caregivers

and facilitators may well be associated with fidelity of implementation.

How Has the Use of the SRS Changed the Way in Which Wraparound Providers Conduct Sessions with the SED Youth and Families Involved?

The qualitative interviews conducted in order to answer my third research question provided an in-depth understanding of how coordinators viewed the process as a whole, and also allowed for narrative responses that presented a more nuanced understanding of the quantitative data sets. Overall, coordinators seemed to feel positively about the wraparound intervention that had been implemented, as well as the way in which families responded. Many of the positive aspects of the SRS identified by respondents (i.e., strengths-focused approach, family narrative, administration of scale) remain true to some of the core components of the wraparound model of care, exemplifying the wraparound program's success in keeping with the values of this model.

The concerns voiced by respondents regarding the administration and accuracy of the SRS and ORS may help to explain the quantitative findings. In particular, concerns about continuously high scores obtained on the SRS throughout the process could suggest that families may not have felt comfortable providing scores that were any lower. If this was the case, high scores on the SRS from the start could have impacted the analyses that were conducted in this study, as high scores from the beginning would not have yielded significant change over time. Research has demonstrated that caregivers of SED youth tend to experience increasing levels of stress overall (Heflinger & Taylor-Richardson, 2004), which impacts the family's level of functioning, including increased conflict, weakening relationships, social isolation, and financial strain (Corliss et al., 2008). As a result of these significant stressors and circumstances, it is possible that caregivers had much else going on in their lives; it may not have been a priority for them to complete the measures in an enthusiastic and mindful way.

With all data considered together, this study might suggest that although useful, the SRS on its own is not as accurate as narrative information provided by families and youth could be. Narrative accounts could serve to bring to life the numerical scores families are asked to assign to each team meeting; the information provided might be more detailed than can be found on a quickly-completed form. Requesting that families provide short narrative written responses after completing the SRS might encourage them to stop and consider how they are scoring each meeting more carefully and deliberately or offer useful details about specific experiences.

Limitations

First, the small sample size in both the quantitative and qualitative portions of this study should warrant a cautious interpretation of the results. As the wraparound project covered by the grant used in this research was intended to serve a small number of families, I was unsurprised by my small sample size of 44 caregivers. However, it is still probable that the results obtained from the quantitative portion of the study offered a less meaningful impression than would have been possible with a larger sample size. Since I was aware of this limitation prior to conducting statistical analyses, I was able to account for it by adjusting my expectations of the strengths of the correlations to determine what could be considered meaningful given the amount of data I was working with. Still, my analysis was further hampered by missing and incomplete data sets. These obstacles are common to real-world data collection, but further limited the data analysis and interpretation.

In addition to the small sample size within the quantitative portion of the study, IPA methodology is inherently limited in generalizability of findings. I interviewed all four of the non-caregiver professionals on the wraparound project to address the third research question, but my findings may be most helpful to the program itself and of less utility to other wraparound

initiatives in other parts of the country. Therefore, the data gathered from this part of the study should also be interpreted with some degree of caution. However, as Smith and Osborn (2008) propose:

> IPA studies are conducted on small sample sizes. The detailed case-by-case analysis of individual transcripts takes a long time, and the aim of the study is to say something in detail about the perceptions and understandings of this particular group rather than prematurely make more general claims. (p. 55)

Therefore, the depth of each participant's experience becomes more meaningful than the breadth, as each individual's process of meaning making is of utmost importance.

Finally, missing data is also a limitation. The dataset that was provided for analysis in order to answer the first and second research questions was incomplete because it did not include a full set of responses on the SRS, the ORS, or the WFI-EZ, and it was also missing the responses from the youths themselves. As mentioned in the data analysis portion of this study, some adjustments were made in the way that the data were used as a result of this missing information. Across both the first and second research questions, only caregiver versions of the SRS and ORS were used. If there had been a more complete set of youth data, their perspectives could have been considered. It is likely, based on past research and on clinical reports in this study, that youth often have a different experience of wraparound and relationships with service providers than their caregivers. It is a limitation of this study that their data and voices were not included.

For both statistical analyses, I hoped to use first and last administrations of the SRS and ORS in order to account for maximum change over time. For several families' data, however, these data points were not available, as coordinators were not always able to administer these

scales consistently at each team meeting. Due to lack of availability of these data points, I used the administrations closest to the first, and closest to the last for some of the 44 cases. With such a small sample, this inconsistency in data collection may also have had an impact on the results obtained from these analyses.

Clinical Implications

Results from this study generate several clinical implications that would be useful in considering how the wraparound model of care is delivered to families. The wraparound model is committed to providing family-centered care coordination, and therefore it becomes essential to include family voices throughout the process. The SRS is one way that this is accomplished, and as a result of this research study, I have four recommendations to make improvements on this method of eliciting feedback from families.

1. Administration of the SRS: The issue of who should be administering the SRS at the end of each team meeting arose as a topic of concern in several of the qualitative interviews that I conducted. Wraparound coordinators often questioned whether administering the SRS themselves yielded the most accurate and honest responses from families; they wondered if their presence caused caregivers to be less transparent about the way they were feeling and expressed concern that family members might be protecting them from hearing their negative feedback.

Therefore, it would be useful to better understand how the method of administration affects the way family members rate each session. To understand how to get the most candid and thoughtful responses would help make the essential component of feedback more effective. Acquiring the assistance of other individuals who can administer the SRS could be a useful way to accomplish the goal of increasing family honesty and openness, which could in turn allow coordinators to

gain more insight into each family's perspective and level of satisfaction. Helping families to feel less concerned with how their responses are interpreted by administrators may elicit more honest and open feedback about the process as a whole. In a similar vein, it is possible that responses are quite different in higher intensity meetings than in lower intensity meetings; it would be interesting to understand the most optimal circumstances for hearing accurate and thoughtful accounts from family members.

2. Validity of inflated SRS responses: Respondents expressed concern that the SRS responses were generally quite high from the start, even before there was much of a relationship with the team. In particular, participants questioned the validity of youth SRS responses. They suggested that younger children offered less accurate reports on their feelings about the meetings. If this were the case, it would be important to determine how to help family members of all ages to more accurately report their actual experience. In addition, there may be components of this measure (and its administration) that are particularly difficult for younger children to understand; they may also have a greater need to please adults in positions of authority. Both ensuring children understand the intent, and a person other than the coordinator collecting the SRS data might allow for coordinators to better capture each family member's voice more openly and effectively.

3. Meaningfulness of the SRS over time: Respondents also discussed their concerns about how the SRS is received by families throughout the wraparound process. Respondents felt as if over time, families became unmoved by the purpose behind the use of the SRS. As a result, concerns were noted about the meaningfulness of this measure to families; respondents questioned the ratings that families provided. Respondents noted that families completed the SRS rather quickly at the end of team meetings, which could

be interpreted in both a positive and a negative light. On one hand, this likely means that families willingly incorporated the use of the SRS into team meetings, that it wasn't an onerous and time-consuming task, and that they identified it as somewhat important. On the other hand, it could also mean that families may have devoted less thought or attention to the measure as they filled it out once again.

Therefore, it is important to consider ways in which families can be re-engaged in the process over time, helping them to sustain investment in data collection. Setting aside designated times apart from regular wraparound meetings, periodically reconfirming the value of the measures, and less frequent administration could all help families maintain interest in the SRS.

4. Valuing the narrative feedback of family members: Although an important element of the process, this study determined that the SRS was not the only way in which coordinators understood the success of team meetings. In addition to this concrete measure provided by the SRS, coordinators more readily relied upon verbal feedback and clinical cues that they were receiving from families during meetings. All respondents had some level of clinical training, and were therefore equipped to monitor families' responses to interventions in real time. As a result, it is equally important to determine a way for this impressionistic type of family feedback to be included. It is possible that family's narrative responses might be captured in a more formal way, which could prove to enrich the quantitative data provided by the SRS.

Future Research

This study serves as the beginning of a larger discussion about the use of process-oriented measures in a wraparound team-meeting setting. As a result, three areas of additional research might be worth pursuing. First, it would be useful to alter the way in which the SRS is

administered in order to determine if this would affect the ratings provided by families. Many respondents expressed concern about high scores on this measure. Altering this methodology (i.e., administering at different times, having a third party administer the measure, and explaining the need for honest feedback before each administration) might yield more meaningful and varied responses from family members.

Second, it would be useful to repeat this study with a larger body of data (i.e., more families participating, more youth responses) in order determine if a clearer set of significant results would emerge. Although states vary in their wraparound strategies, it would be useful, where possible to pool data for larger numbers. Observing and understanding how other states approach this model of care and investigating their practice related to gaining families' perspectives about their experience could further establish methods of gathering this information that might be more portable across state lines.

Finally, it would be beneficial to interview the youth and caregivers who receive wraparound services directly in order to gain a narrative perspective on their experiences with participation. Considering family voice as a component of this program has proven to be essential and has certainly contributed to its success. In particular, it will be important to make sense of differences in responses for caregivers and youth so that wraparound interventions work most effectively for all family members.

Concluding Remarks

Although I used archival data for this study, the values of wraparound connect closely to my own clinical work. Throughout my several clinical placements, I have interacted with many children and adolescents who fit the SED criteria. Most of their families struggle to obtain the support they need in a disjointed care system. As a result of my training and the various settings I

have worked in, I have come to appreciate the dedication and hard work put forth by community mental health providers to compensate for the gap that is present in the current care system. From my observations, providers often put in extra time and effort to collaborate with outside agencies and community supports that are in the best interest of their patients. At the same time, these families contend with socioeconomic barriers that prevent them from having the resources to provide the necessary interventions that their children require; they need more than they are getting from other service providers, community agencies, and extended family.

I have recently completed a referral to obtain a wraparound coordinator for one of my most distressed families. I have therefore had the opportunity to begin to participate in these meetings as a psychologist in the "team member" role. My participation in this process has given me an inside look at the significance of this type of an intervention for a distressed family. Although this particular case is still relatively new to wraparound care, I have already observed a unification of individuals from all parts of this family's life as they gather together to serve the best interest of the child.

What stood out for me about the wraparound program that I investigated in light of my experiences was the caring and supportive nature of the program. Despite the extensive requirements and responsibilities each team meeting placed on the facilitator, the team as a whole maintained its commitment to assisting families to succeed in their own ways based on their particular goals and strengths. The reality of the overworked and underfunded community mental health system oftentimes does not leave room for the type of care that the wraparound approach provides: A more cohesive and intentionally supportive alternative. Some community mental health organizations are already implementing similar processes such as engaging in team meetings and hiring case managers in order to bolster their practice. Since the wraparound model

is designed to provide this type of support and more, perhaps the mental health field could adopt this model as best practice. It is my hope that this study has provided recommendations that can contribute to advancing and strengthening this coordinated service further by improving the value and efficacy of wraparound feedback.

References

American Psychological Association. (2010). *Ethical principles of psychologists and code of conduct*. Washington, DC: American Psychological Association.

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., & Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. *European Archives of Psychiatry and Clinical Neuroscience*, *256*(3), 174–186. https://doi.org/10.1007/s00406-005-0624-4

Anker, M., Duncan, B., & Sparks, J. (2009). Using client feedback to improve couple therapy outcomes: A randomized clinical trial in a naturalistic setting. *Journal of Consulting and Clinical Psychology*, *77*(4), 693–705. https://doi.org/10.1037/a0016062

Armstrong, K., Dedrick, R., & Greenbaum, P. (2003). Factors associated with community adjustment of young adults with serious emotional disturbance. *Journal of Emotional and Behavioral Disorders, 11*(2), 66–76. https://doi.org/10.1177/106342660301100201

Becci, A. A., Brook J., & Lloyd, M. H. (2015). Co-occurrence of parental substance abuse and child serious emotional disturbance: Understanding multiple pathways to improve child and family outcomes. *Child Welfare*, *94*(4), 71–96. Retrieved from: http://web.a.ebscohost.com.antioch.idm.oclc.org/ehost/pdfviewer/pdfviewer?vid=1&sid=b99224f4-83c6-40aa-b9a8-ed51da870d0e%40sessionmgr4006

Bloomberg, L. D., & Volpe, M. (2008). *Completing your qualitative dissertation: A roadmap from beginning to end* (2nd ed.). Thousand Oaks, CA: SAGE.

Breault, C., Lewis, S., & Taub, J. (2005). Wraparound case management for children with serious emotional disturbance: A qualitative look at caregivers' experiences. *Psychiatry Information in Brief, 2*(2). Retrieved from http://escholarship.umassmed.edu/pib/vol2/iss2/1

Bruns, E. J., Burchard, J. D., Suter, J. C., Leverentz-Brady, K., & Force, M. M. (2004). Assessing fidelity to a community-based treatment for youth: "The wraparound fidelity index." *Journal of Emotional and Behavioral Disorders*, *12*(2), 79–89. https://doi.org/10.1177/10634266040120020201

Cohen, J. (1992). A power primer. *Psychological Bulletin*, *112*(1), 155–159. https://doi.org/10.1037/1033-2909.112.1.155

Copp, H. L., Bordnick, P. S., Traylor, A. C., & Thyer, B. A. (2008). Evaluating wraparound services for seriously emotionally disturbed youth: Pilot study outcomes in Georgia. *Adolescence, 42(*168), 723–732. Retrieved from: http://web.b.ebscohost.com.antioch.idm.oclc.org/ehost/pdfviewer/pdfviewer?vid=1&sid=8b7e8d01-0d09-4099-8af5-ec5b62326174%40sessionmgr120

Corliss, B., Lawrence, E., & Nelson, M. (2008). Families of children with serious emotional disturbances: Parent perceptions of family resources and stressors. *Child and Adolescent Social Work Journal, 25*(4), 271–285. https://doi.org/10.1007/s10560-008-0126-0

Costello, E. J., Messer, S. C., Bird, H. R., Cohen, P., & Reinherz, H. Z. (1998). The prevalence of serious emotional disturbance: A re-analysis of community studies. *Journal of Child and Family Studies*, *7*(4), 411–432. https://doi.org/10.1023/A:1022901909205

Cox, K. (2006). Investigating the impact of strength-based assessment on youth with emotional or behavioral disorders. *Journal of Child and Family Studies, 15*(3), 278–292. https://doi.org/10.1007/s10826-006-9021-5

Davis, M., Yelton S., Katz-Leavy, J., & Lourie, I. S. (1995). Unclaimed children revisited: The status of state children's mental health service systems. *Journal of Mental Health Administration*, *22*(2), 147–166. https://doi.org/10.1007/bf02518755

Dulcan, M. K. (2010). *Dulcan's textbook of child and adolescent psychiatry*. Arlington, VA: American Psychiatric Association Publishing.

Duncan, B., Miller, S., Sparks, J., Claud, D., Reynolds, L., Brown, J., & Johnson, L. (2003). The session rating scale: Preliminary psychometric properties of a "working" alliance measure. *Journal of Brief Therapy, 3*(1), 3–12. Retrieved from https://heartandsoulofchange.com/content/resources/viewer.php?resource=article&id=23

Eberharter-Maki, E.,Western Regional Resource Center, & Idaho Department of Education. (1996). *Students with serious emotional disturbance: A legal guide to identification*. Washington, DC: U.S. Department of Education. Retrieved from http://files.eric.ed.gov/fulltext/ED408727.pdf

Effland, V. S., Walton, B. A., & McIntyre, J. S. (2011). Connecting the dots: Stages of implementation, wraparound fidelity and youth outcomes. *Journal of Child and Family Studies*, *20*(6), 736–746. https://doi.org/10.1007/s10826-011-9541-5

Forness, S., & Knitzer, J. (1992). A new proposed definition and terminology to replace 'serious emotional disturbance' in individuals with disabilities education act. *School Psychology Review, 21*(1), 12–20. Retrieved from http://web.a.ebscohost.com.antioch.idm.oclc.org/ehk5/detail/detail?vid=0&sid=fa4e6241-ef21-4b22-8ef3-e189943c596e%40sessionmgr4010&bdata=&preview=false#AN=9604173887&db=aph

Hansen, M., Litzelman, A., Marsh, D. T., & Milspaw, A. (2004). Approaches to serious emotional disturbance: Involving multiple systems. *Professional Psychology: Research & Practice*, *35*(5), 457–465. https://doi.org/10.1037/0735-7028.35.5.457

Heflinger, C. A., & Taylor-Richardson, K. D. (2004). Caregiver strain in families of children with serious emotional disturbance: Does relationship to child make a difference? *Journal of Family Social Work*, *8*(1), 27–45. https://doi.org/10.1300/J039v08n01_02

Hocutt, A., McKinney, J., & Montague, M. (2002). The impact of managed care on efforts to prevent development of serious emotional disturbance in young children. *Journal of Disability Policy Studies, 13*(1), 51–60. https://doi.org/10.1177/10442073020130010501

Johnson, I. D., Miller, S. D., & Duncan, B. L. (2000). *The Session Rating Scale 3.0.* Retrieved from https://heartandsoulofchange.com/content/measures/login.php

Knitzer, J. (1982). *Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services*. Washington, DC: Children's Defense Fund.

Kutash, K., Duchnowski, A., Sumi, W., Rudo, Z., & Harris, K. (2002). A school, family, and community collaborative program for children who have emotional disturbances. *Journal of Emotional and Behavioral Disorders, 10*(2), 99–107. https://doi.org/10.1177/10634266020100020401

Lambert, M. (2004). *Administration and scoring manual for the OQ-45.2 (*rev. ed.). Salt Lake City, UT: OQ Measures, LLC.

Leichtman, M. (2006). Residential treatment of children and adolescents: Past, present, and future. *American Journal of Orthopsychiatry, 76*(3), 285–294. https://doi.org/10.1037/0002-9432.76.3.285

Malmgren, K. W., & Meisel, S. M. (2002). Characteristics and service trajectories of youth with serious emotional disturbance in multiple service systems. *Journal of Child and Family Studies, 11*(2), 217–229. https://doi.org/10.1023/A:1015181710291

Mark, T. L., & Buck, J. A. (2006). Characteristics of U.S. youths with serious emotional disturbance: Data from the National Health Interview Survey. *Psychiatric Services, 57*(11), 1573–1578. https://doi.org/10.1176/appi.ps.57.11.1573

Mears, S. L., Yaffe, J., & Harris, N. J. (2009). Evaluation of wraparound services for severely emotionally disturbed youths. *Research on Social Work Practice*, *19*(6), 678–685. https://doi.org/10.1177/1049731508329385

Mertens, D. M. (2014). *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods* (3rd ed.). Thousand Oaks, CA: SAGE.

Miller, S. D., & Duncan, B. L. (2000). The Outcome Rating Scale. Retrieved from https://heartandsoulofchange.com/content/measures/login.php

Miller, S., Duncan, B., Brown, J., Sparks, J., & Claud, D. (2003). The Outcome Rating Scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy, 2*(2), 91–100. Retrieved from https://heartandsoulofchange.com/content/resources/viewer.php?resource=article&id=26

Osher, D. M., Quinn, M. M., & Hanley, T. V. (2002). Children and youth with serious emotional disturbance: A national agenda for success. *Journal of Child and Family Studies, 11*(1), 1–11. https://doi.org/ 10.1023/A:1014774526006

Painter, K. (2012). Outcomes for youth with severe emotional disturbance: A repeated measures longitudinal study of a wraparound approach of service delivery in systems of care. *Child & Youth Care Forum: Journal of Research and Practice in Children's Services, 41*(4), 407–425. https://doi.org/10.1007/s10566-011-9167-1

Pullmann, M. D., Bruns, E. J., & Sather, A. K. (2013). Evaluating fidelity to the wraparound service model for youth: Application of item response theory to the wraparound fidelity index. *Psychological Assessment*, *25*(2), 583–598. https://doi.org/10.1037/a0031864

Rashid, T. (2015). Positive psychotherapy: A strength-based approach. *The Journal of Positive Psychology*, *10*(1), 25–40. https://doi.org/10.1080/17439760.2014.920411

Reese, R., Norsworthy, L., & Rowlands, S. (2009). Does a continuous feedback model improve psychotherapy outcomes? *Psychotherapy: Theory, Research, Practice, Training*, *46*(4), 418–431. https://doi.org/ 10.1037/a0017901

Robinson, K. E. (2000). Outcomes of a partial-day treatment program for referred children. *Child and Youth Care Forum, 29*(2), 127–137. https://doi.org/ 10.1023/A:1009453428705

Rosenthal, J. (1996). Qualitative descriptors of strength of association and effect size. *Journal of Social Service Research, 22*(4), 37–60. https://doi.org/10.1300/j079v21n04_02

Rudo, Z., Powell, D., & Dunlap, G. (1998). The effects of violence in the home on children's emotional, behavioral, and social functioning. *Journal of Emotional and Behavioral Disorders*, *6*(2), 94–113. https://doi.org/10.1177/106342669800600203

Schuman, D., Slone, N., Reese, R. J., & Duncan, B. (2014). Using client feedback to improve outcomes in group psychotherapy with soldiers referred for substance abuse treatment. *Psychotherapy Research*, *25*(4), 396–407.https://doi.org/10.1080/10503307.2014.900875

Simmons, C. A., & Lehmann, P. (2013). *Tools for strengths-based assessment and evaluation.* New York, NY: Springer.

Smith, J. A. (2008). *Qualitative psychology: A practical guide to research methods* (2nd ed.). Los Angeles, CA: SAGE.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method, and research.* Los Angeles, CA: SAGE.

Smith, J. A., & Osborn, M. (2008). Interpretive phenomenological analysis. In J. A. Smith (ed.), *Qualitative psychology: A practical guide to research methods* (pp. 25–53). Los Angeles, CA: SAGE.

Soenen, B., D'Oosterlinck, F., & Broekaert, E. (2013). The voice of troubled youth: Children's and adolescents' ideas on helpful elements of care. *Children and Youth Services Review, 35*(9), 1297–1304. https://doi.org/ 10.1016/j.childyouth.2013.05.005

Sparks, J. A., & Muro, M. L. (2009). Client-directed wraparound: The client as connector in community collaboration. *Journal of Systemic Therapies, 28*(3), 63–76. https://doi.org/10.1521/jsyt.2009.28.3.63

Stroul, B., & Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances* (Rev. ed.). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

U.S. Department of Education. (1998). Twentieth annual report to Congress on the implementation of the Individuals with Disabilities Education Act. Washington, DC: U.S. Department of Education.

Vernberg, E. M., Roberts, M. C., & Nyre, J. E. (2007). The intensive mental health program: Development and structure of the model of intervention for children with serious emotional disturbances. *Journal of Child and Family Studies*, *17*(2), 169–177. https://doi.org/ 10.1007/s10826-007-9157-y

Walrath, C., Nickerson, K., Crowel, R., & Leaf, P. (1998). Serving children with serious emotional disturbance in a system of care. *Journal of Emotional and Behavioral Disorders, 6*(4), 205–213. https://doi.org/10.1177/106342669800600402

Wraparound Evaluation and Research Team. (2006). Wraparound Fidelity Assessment System Team Observation Measure. University of Washington.

Wraparound Evaluation and Research Team. (2010). Wraparound Fidelity Index, Version 4: Summary of relevant psychometrics, reliability, and validity studies. Retrieved from http://depts.washington.edu/wrapeval/docs/Psychometrics_WFI_April_26_2010.pdf

Appendix A: Tables and Figures

Table 3

Transcript 1 of 4, Using Interpretive Phenomenological Analytic Methods to Analyze Data

Exploratory Comments	Transcript Contents	Emerging Theme Titles
	Interviewer: So, basically I have a few questions I want to ask you about your experience. They're based mainly around one of the measures that you guys used, which I'm calling the Session Rating Scale, but I believe you guys called it the Team Meeting Rating Scale? Participant: Yup, team meeting. Interviewer: That's going to be where the majority of my questions come from, but I really am just interested in your experience of being a part of this program, so feel free to say whatever you feel like would be helpful for me to know as we go along. Participant: Okay.	
• Many responsibilities • Focus on fidelity • Her role as overseeing the coordinators • Working with challenges / barriers to service delivery • Adherence to practice model • Collaborative coaching process, working together	I: So, it sounds like from your e-mail you have been doing this for about two years. P: Little over two years, yep I: Can you explain what that entailed? P: Um so what that entailed was meeting with the coordinators on a regular basis on primarily working with them on implementing the wraparound practice model with fidelity. So we would meet and talk about where they were in the process, how things were going, and I would also	• Adherence / Fidelity • Collaboration • Responsibility • Feeling overwhelmed

	work with them when there were difficulties, challenges or barriers arise we try to work together to try to move forward with those, always going back to the practice model.	
• Maintaining fidelity • Different strategies to get there- not all families are the same • Different strategies work for different families • Individualized treatment planning	I: So kind of using the wraparound model to inform what you were doing with coordinators? P: Right, and that was pretty much my role, which was to coach them in maintaining fidelity of the model but also having to use different strategies and ideas and ways to use the model with fidelity but at the same time individualize it to different situations, different settings, different families, that kind of thing.	• Fidelity • Individualized treatment planning
• Art versus science of model • Structured versus individually tailoring to families • Making the experience more palatable this way, also makes the model easier to use	I: Right, because I can imagine that the model, there are so many specific things in the model that need to be included, and I can imagine that that would be difficult thing to keep in mind. P: Right. So we always talk about the art and the science. So the science is you know you have a step by step process. Not really step by step but a pretty structured process, and on the other hand you have to individualize it to families and use it, so that is the art.	• Individualized treatment planning • The art of the process • Skillful approach
• Longstanding experience backing this leadership position	I: Yeah, I really like that explanation. It sounds like you have a lot of previous experience with supervising	• Experience

	people based on what you are already saying P: Um, yes. I did work in administration in school districts for a long time.	
• Use of measure consistently in team meetings • Families understanding that their opinions mattered • Measure as part of a larger process (plan of care) • Use of measure as a way to understand how comfortable and satisfied families were with the team • Use of measure to make improvements (what is and isn't working for this family?)	I: Oh, that's awesome. So, I think we can get started with my questions now if that is okay. My first question is: How did you help each wraparound coordinator to make sense of why they were administering the SRS specifically in wraparound sessions? P: So, we use that, they did that every time they had a team meeting. They incorporated it into the plan of care, because we wanted families to know, how they felt about how the meetings were going, this was important. They used this every meeting, and the results would go on the plan of care, and then I would review the plan of care. So it was just part of the review of what they were doing. And the idea was to have them look at the team rating scale to understand how comfortable families and satisfied families felt with the team, and then try to look at if there were ways that the team was working that weren't necessarily fitting for the family.	• Family centered • Feedback
• Coach's understanding of how measures made coordinators feel • Did not get the sense that coordinators felt	I: Okay. I just wonder if you ever got any hesitance or resistance from the coordinators about using this, because I can imagine that it	• Impact on coordinators

uncomfortable with this measure being used • Impression that the measure got very little reaction out of coordinators	kind of exposes in them in a way that may make them feel vulnerable almost, I don't know. P: I don't feel like they ever really felt um, that they were being rated. I didn't get that sense. I think that it could be perceived that way, but I really didn't get the sense that they felt that way. And obviously in coaching, it is different than supervising.	
• Coaching as different than supervising • Coaching as assisting people to get better at what they are doing • Viewing the process of the team meeting as more significant than the measure itself	I: How is it different? P: Umm, supervising is more making sure, I think about compliance, making sure people do what they need to do, and in coaching you're helping people to get better at what they are doing. So it is a little bit of a different approach. So I certainly wouldn't say "oh my goodness, the team rating scale was a 6 this week, what's the matter?" And we didn't dwell on the team rating scale, we looked more at the process and at other aspects of the plan of care too, so it was just one small piece, I wouldn't say it was a major part. I: Okay, so it wasn't a big part. P: Right.	• Role as Coach • Service delivery • Team Process
• Process of wraparound is documented on the plan of care. • Inclusion of family needs, strengths, family's vision • Family centered approach • Meaningful, personal	I: When you say the plan of care, can you tell me a little bit about what that entailed? P: So the plan of care is the document that we use to pretty much document the process of wraparound. And so it includes um, the needs, the strengths of the family, the family's vision.	• Family strengths • Individualized treatment planning • Family centered • Documentation

document • Documenting the process as a whole	So basically it is a document that pretty much encapsulates what is going on. And it isn't like a treatment plan where you just fill in the blanks, you know, it is meant to be a lot more meaningful. Not important as a document itself but it is documenting what is going on in the process.	
• The process of wraparound helps coordinators to come to conclusions / create the plan of care	I: Right, and it sounds like the fact that it is so individualized to each individual family speaks to the meaningfulness of it for each family specifically. P: Right, right, and so it is not like you can just put things on paper, you have to work through the process to get what it is that you are going to put on the plan.	• Role as coordinator
• Coach views coordinators as taking this measure into consideration • Many other ways that coordinators and coach understand how things are going during team meetings	I: So the next question I have is, how do you think that the inclusion of the SRS has affected wraparound session for coordinators based on their reports to you? P: Umm I think that they consider it and they want you know it to, the scale to show satisfaction and comfort with the process, but I think there is also a lot of other things that are important measures of how things are going.	• Impact on coordinators • Indicators of meeting progress
• Family discussion / reports in team meetings, the narrative account seems to be more important that rating scales • Interaction between	I: Like what? P: Like, what the family is saying, how they um, feel, it's hard to, it's more what the family is saying and what they are reporting in narrative as much as what they are putting	• Family narrative • Personal process

family and coordinator as more meaningful • Getting the sense that this participant is envisioning a more personal process than what is captured on the measure	on the form. I: So it sounds like the more meaningful part is the actual interaction between the family and the coordinator? P: Yes, definitely.	
• Both useful and not useful components of using this measure • Helps coordinators to understand how the meetings went • Using this measure also gives coordinators the ability to track results over time to begin to understand changes that may have occurred • Changes prompt coordinators to think about what was different, or if a certain conversation did or did not go particularly well • Different families respond differently on rating scales- not consistent across families • More consistent within families • Within team meetings, there is a lot to accomplish, feels like an inconvenience to have to include one more step • Coordinators feeling overwhelmed with everything that had to get done • Over time, it seems that the use of the measure	I: So my next question is, in what ways have you heard about the SRS being useful or not useful in influencing what coordinators accomplish in wraparound sessions? P: I think that, um, it is useful in terms of they get a sense of how families felt the meetings went, and if they get results that are different than how they usually feel, um, then they can look at what was it about this meeting that didn't go well, or didn't go particularly well, you know, why is this meeting different. And different families rate differently, like some families rate low consistently, and other families may rate high consistently. Sometimes they never rate it well because they don't necessarily like meetings. So it varies between families, so you are looking individually at each family at what is different and at what the trends are. So that is how it would be useful. I think that the problem is, when they are doing team meetings, there is so much to include and so much to get done in a short period of time, that sometimes it would feel like a burden to have to do it at the end. I think they got on a	• Indicator of meeting progress • Family centered • Responsibility • Feeling overwhelmed • Drawbacks of Administration

	was more accepted as a part of the process	roll with it, but at the beginning it was like oh my goodness, I have to get all of this done and I have to do this scale.	
	• In the beginning, it seems like coordinators had a hard time seeing the value in using the measure • Varying levels of comfort with using the measure depending on the families and coordinators	I: Right, it's like an extra thing. P: Right, it's like an extra thing, and you don't necessarily in the beginning see much meaning in it, but as it goes on and families get used to it, it can go pretty quickly. And I think different coordinators have different levels of comfort with it, and some of that relates to the different families and how much they are invested in it. And so again, it is always different. I: Yeah, that makes sense. So it sounds like it's useful in the sense that coordinators are able to really keep track about what felt different about a session that made them rate it low or high, and the un-useful part is that it can sometimes feel burdensome and like an extra step in this long and involved meeting. P: Right, exactly.	• Understanding the purpose • Levels of comfort
	• Meetings as very structured- agenda • Review of the whole process and the family's profile of strengths, needs, etc. • Development of ways to determine if family's needs are being met • In addition to the structured components	I: Okay. So you are saying that these meetings are very long and involved, and a lot is going on in the meeting. Can you give me an idea of what goes in the meeting exactly? P: Um, yeah, there is a whole process. Every meeting has an agenda. Oh I don't have it in front of me. But they will review everything about the	• Structure • Adherence / Fidelity • Family Strengths • Feeling overwhelmed • Skillful approaches

of the meetings, family issues also come up • High need, crises arise- these things are addressed in team meetings as well • "Jam-packed" - overwhelming amount of things to accomplish • Requirement of some sort of skill to be able to engage in this process successfully with families • Confidence in coordinator's level of skill in this particular program	process: They review the family vision the whole wraparound process is focused on strengths so they review the strengths of the family, and then needs are identified, so depending on where they are on the process they are working on identifying needs or reviewing these needs, and then they have to develop benchmarks to show if the needs are met, how would they know that. Those have to be measureable in some way, so there is a lot that has to get done. And once they have the benchmarks, then the meetings are about reviewing progress and reviewing benchmarks. And in doing all of that, in the context of the families have a lot going on, and that is why they are involved in wraparound. So there also might be crises that arise or difficulties that may need to be addressed, so it is jam-packed. And you have to be a pretty skilled person to do it well, we are lucky that we have good people.	
• Measure not specifically addressed in each coaching session- not a significant part • Lots of other things to get to during coaching session • Somewhat of a dismissal of the team meeting rating scale	I: My next question is, can you think of a time when your discussion of the team meeting rating scale with a coordinator either contributed, positively, negatively, or maybe both, to a conversation about their work? P: Ummm, I can't think of a specific time to be honest with you, and we wouldn't discuss the team meeting rating scale in every coaching session. So just to be clear that we weren't	• Purpose of coaching session • Unimportance of scale

	spending, that wasn't necessarily a talking point in every coaching session. There were so many other things that we were focused on.	
• Sometimes the measure was brought up in relation to the plan of care • More often the coordinators themselves would bring it up when ratings were not as high as they were expecting • Other more narrative based information was used to fill in the blanks about what happened in a particular team meeting • SRS and narrative reports tended to match up relatively well	I: Absolutely, that makes sense. So, when it was brought up in coaching sessions, what was the context around how it was brought up and used? P: It was, it would be, like reviewing the plan of care and you know, how did the family rate it, it's right there on the plan of care. Or, more often than not, I think the coordinators would bring it up and would say "oh they didn't rate it that well." But they also had a lot of other narrative information to provide, saying you know this is what they see going on. And it would also match pretty well, I: Between what the family is narratively reporting and the SRS scores? P: Yes.	• Impact on coordinators • Other indicators of process/ progress
• Information about how team meetings went often came from caregivers' perspectives • Behavioral information from outside of the meetings from youth was also indicative of utility of wraparound process • Requirement that coordinators themselves need to be skilled at engaging the youth	I: Okay. And so, do you feel like the coordinators were getting more information from the parents or from the youth? P: I think more often than not it was from the caregivers, but um not always. Again, it is so individualized, and a lot depends on the age of the youth as well. With younger youth I think we would get more information from outside of the team meetings rather than younger youths participation in the actual meeting.	• Perspectives on progress • Skillful approaches

	I: Yeah, I bet it would be difficult for them to tolerate this kind of a meeting in general. P: Yes. And the coordinators have to be pretty skilled in getting the youth involved.	
• Perception that program was a success • Resources that were needed to make it a success were present • A focused process was necessary to make this program work	I: Okay. So, overall thinking about how your experience was with this program, because I know for you it has ended, what was your experience, how did you feel like it went, do you feel like it was successful? P: I think it went really well. I think it was great, I think the resources that were needed were put into it, I think it was very focused, we had all of the, you know, things to implement a process or an initiative that you needed. I think it went really well.	• Need for resources • Structure • Successful Parts of Program
• Concern for when the program continues seems to be that less resources will be available	I: That's great. Were there any areas of concern about the program? It seems like you feel very positively about the program so maybe not? P: I am very positive about it, I'm not coaching now, I am hoping that I will be able to do that. I am concerned moving forward not having all of the pieces in place that were in place.	• Need for resources
• Need for sustained resources and supports in order to have continued success • Hope that coaching will still be a part of it- value in coaching • View of coaching as	I: Because things are changing based on the grant? P: Yeah, things are changing. And I just, I think it went so well because the resources were well allocated, and um all of the supports were in place, and I hope that in sustaining	• Need for resources • Value in coaching

essential to any kind of practice • Coaching as a way to offer a fresh perspective	the practice that all of the basic resources. I mean all of the money resources won't be there because that's just not possible, but I hope that the basic resources will be there, including coaching, you know it sounds funny because I'm not doing it now but I think that if you are going to have a practice that is going to be successful you need coaching, I just believe this in general. Even if you are an expert in something, another perspective is always important.	
• Interest in continued engagement in this project • Seems like it was rewarding / interesting enough to want to continue • Enthusiasm about program	I: Absolutely. So, you would be interested in doing something like this again if the opportunity presented itself. P: Oh, absolutely.	• Successful parts of program
• This is an elaborate process, SRS was a small component of this larger process	I: And to be honest, that is all of the questions I had for you, but is there anything else you wanted to add about your experience with the team rating scale or anything related to your experience that would be helpful for me to know? P: I don't think so. Just the piece that there are so many pieces to it, and the process that the team rating scale was one piece of it, and that's all.	• Complicated process

Table 4

Transcript 2 of 4, Using Interpretive Phenomenological Analytic Methods to Analyze Data

Exploratory Comments	Transcript Contents	Emerging Theme Titles
	Interviewer: So basically, like I think I explained to you when we spoke last week, these are mainly questions about 1 of the measures that you had used when you were part of this program called the team meeting rating scale which I am calling the SRS, those are the same thing. Participant: Okay, yup.	
• Longstanding experience in program	I: So, you are no longer in the program, right? P: Not anymore, no. I: Okay, so how long were you doing it for? P: Um, it started in June 2014, I did the entirety of the grant through September 2016.	• Experienced clinician
• Positive experience • Groundbreaking work, not just about this one project • Passion / enjoyment of job	I: Okay. So how was it overall for you? P: It was great. It was a great experience, it was you know, the experience was more than just learning the wrap process, we really helped to create the program for the state of (name of state). It was great, I really loved the job. We worked with	• Positive experience • Meaningful work • Coordination within community

	different agencies, and really helped promote the program to get more providers on board. It was great. I: That's awesome. And what are you doing now? P: I am a probation parole officer for the state of (name of state). It's with adults, I'm not working with kids as much now.	
• SRS felt natural to administer • Appropriateness of administering some measures over others • SRS felt helpful for most families • Families feeling as if they could be honest with their team members about the process as a whole • Caregiver capacity- giving the families a voice in the process • Families would also sometimes rate meetings higher than what the coordinators would have thought • Wanting to rate the meeting high because the family likes the facilitator • Difficult meetings did not always lead to lower ratings on the SRS • Younger youth had a more difficult time understanding the measure itself • More appropriate for 9-10 year olds and above, who responded better to it	I: Oh wow, that sounds so interesting! So my first question for you is what was your experience with administering the team meeting rating scale and had a you feel like you helped your clients to make sense of why they were completing it? P: Yeah, I think, and I know we spoke a lot with Antioch about this, I think the team meeting rating scale was much more natural to implement with families than the ORS was. I think it was because of not only the environment we were in, but, yeah it just felt more natural because when we were doing the ORS, we would walk into some situations that you can't plan for and to have a family, you know, fill out a questionnaire wasn't always appropriate. But with the team meeting	• Administration • Utility of scale • Family Honesty • Family voice • Family capacity • Inaccuracy of ratings • Age of youth • Natural implementation

	rating scale, I saw two things. I saw that it was really helpful for most families, where they were able to kind of share and feel that they could be honest with the team members about how the meetings were going. It kind of helped to build that sense of caregiver capacity that we were really trying to promote through the program. But I also found sometimes families would be nice and rated higher but then during the discussion you could tell that they were kind of just rating it higher because they like the facilitator. I: Not necessarily because it was going especially well. P: Yes, right. Even if we had some difficult meetings and parents felt like nothing really cannot accomplish on their end, they would still rate the meeting pretty high. And I found that youth, younger youth, like I had a 7 year old, who had a difficult time understanding the tool. But I think with kids who are 9 or 10 and up they really enjoyed it. They responded well to it. They were really honest so that's good.	
• Accuracy of ORS scores may also be somewhat	I: So it sounds like the ORS was not always	• Inaccuracy of ratings

skewed given the context in which they were administered • ORS indicating caregiver stress • Level of stress in the home seemed to be related to higher ratings on the ORS	appropriate to administer because of the times when you were administering it, like after a crisis, which made it feel much less appropriate. P: Right. I: And do you feel like because of the weirdness of the timing of administering, you got accurate reads for the ORS? P: Not always, um, sometimes. You know I am thinking of specific families where it was more common and there were a lot of crises and difficulties within the home. And the ORS kind of showed how that affected the caregiver and the stress level, and how the caregiver reported, like even when the questions on the ORS were about personal feelings, the caregiver always rated lower. Um, I think one of the things I saw though is, there was a correlation between the level of stress in the home, and the higher on the ORS parents would rate, I think it was like question 3, they would always rate "outside of the home" was higher than in home. I: Okay, which makes sense if they are experiencing lots of	• Rating scale indicators • Acuity of population served

	difficulty in the home P: And they were kind of saying like "get away." Haha.	
• Use of SRS to help coordinator prepare for the next team meeting • Family voice incorporated into team meeting plan • Use of measure to facilitate a larger conversation about the meeting process • It seems like this facilitator used the measure to be able to ask process-oriented questions about how the sessions were going, and what could be done differently / better • Emphasis on the process as slower-paced, not a "quick fix" • Helping families to feel that they are making better progress, even if all of their problems have not disappeared	I: Yeah, I bet! Okay, so the next question is, how had the inclusion of the team meeting rating scale in the wraparound session shape the way that you approached the session, or did it even? P: Um, I think that the SRS, since it was such a natural scale to use, it really helped, um, I think the way I explained it to families was that from them completing this, it really helped to prepare for the next meeting, prepare for future meetings with providers because it was really their voice, to tell us how things were going. And I would use that to have that conversation with a family It was a nice way to kind of start that conversation, like "Oh, hey, I looked at your scores from the other day and I saw that you rated this meeting a little bit lower than last time, you know, what was different, what could we do better as a team, you know, what would you like to see in the future?" So really starting to help the families to kind of um, I had a few families who kind of felt	• Ease of use • Natural tool • Informing future meetings • Evaluation of process • Alternative measure of progress • Meaning of success • Facilitating conversations

	that they wanted these quick fixes, and the wrap meetings, it's a slow process. So a lot of times families, especially caregivers would be really frustrated, in their minds they would, it was hard for them to see much success. So this tool was a nice way to say to them "I understand where you are coming from, I see the rating scale is lower, so what can we do during the next meeting, what can we talk about, or, how can we structure this so that you feel that we are making better progress.	
• family -centered approach • Questions within the measure are very simple and direct, easy to understand • Consistent with overall approach with families: direct, honesty • Breaking down parts of the meeting that are important, highlighted this for families • Emphasis on the fact that the meetings did not only exist to talk about the problems, but also about the aspects of treatment / systems of care that were working for families • Positive and strengths-based approach • Negative side had to do with families who had been exposed to this measure for a longer time, may not have taken the time to answer honestly / take their time	I: Yeah, so it sounds like this scale made it easier for you to frame future conversations and kind of like, really stick to the ideal of making it feel very family centered, because it was really all about their opinions. P: Yeah, exactly. I: Okay, so the next question is, in what ways did you view the use of the SRS as useful or not useful in informing what you did in the wraparound sessions? So, can you maybe like, can you identify some useful parts and some not useful parts? P: Umm, I think, useful, um, was, I'm trying to	• Family centered • Simplicity • Honesty • Strengths based approach • Successes • Exposure of measure over time • Accuracy of measure • Meeting structure

with it	think of the questioning, um, I think with the questions they were pretty simple and direct, which, a lot of what we did was we tried to be direct and honest, and using family language, and that really helped with them, because it broke down for the team as well as for the family some parts of the meeting, like if they felt heard and understood, and if what we worked on today, did it work for you with the way we worked together, things like that. Um, and it kind of broke down for the family what each meeting was about, not just we were going to be there to talk about all of the problems in the home, but we were there to really look at what was working for you guys. So what worked about it was that it was positive, strengths-based language. Um, but I think really one of the only negative sides of it was that some of the families who had been in the program for a while they kind of were just like "oh here is this thing again, let me just circle my numbers real quick."	
• Decrease in level of excitement about this part of the process • More of a burden, or something extra to do that may have lost its initial	I: Got it, so like, do you feel like in those cases it felt like a burden, or an extra piece of paperwork? P: I think it was at that	• Level of enthusiasm • Burden • Family investment • Family overwhelmed

meaning • Less investment moving forward • Families as overloaded with services / meetings / appointments, could also impact their level of investment in every part of the process • Less time to do the miniscule parts of the process • When it gets to the point when families are this busy, it seems that it could also be an indication that they are doing very well, and that it could be time to fade the service out	point, it was just like, "okay.." there wasn't as much excitement anymore of like "yeah let me tell you how I feel." It was more of just like "okay let's just get this over with." I: Yeah, so, what you had talked about before about it being valuable to help you set up future sessions more successfully, they kind of were no longer invested in that part of it. P: Mmmhmm, right. And I found that in some meetings, some families were so busy that they were squeezing us in, so of course, they were involved in other things. Part of it is, how do you know when a family is ready to transition and all of that. But you know, some families we would have a meeting from 9:00 to 10:00 at the school, and then mom had to rush to work. So sometimes there just wasn't that time. I: To sit down and think about this extra thing. P: Right, yeah.	• Measure of success
• SRS helped to shape meetings, helped facilitators to gain comfort with the process • This measure helped to guide not only families, but	I: Okay, great. And I only have one more question for you, and that is if you can possibly describe a specific experience where your use of the SRS was	• Measure as guide for meeting • Families as individuals • Team uniqueness • Removal of blame

also facilitators about what should be focused on at the core • Acknowledgement that every family / team is different, but this scale helped to bring some consistency to the process • Emphasis on what was going to work for this family in particular • Parents not wanting judgement about issues occurring for their children • SRS helped to remove blame, deemphasizing anything that was done wrong over the years, and emphasizing what could be done to support the family at this time	incorporated into your session in a positive or a negative way? P: Okay, um. Well I actually tell the story of how my first team meeting went. We were prepared, we were so ready for it, um, you know we had only been in the program for about a month. We kind of had this meeting quite quickly, um, and it completely bombed. I: Oh, no! P: Yeah! But, you know I think we grew over those few years and we got more comfortable with everything. I think that every team looks different, but an overall positive thing from that is that it helped to shape meetings, and helped facilitators to feel comfortable facilitating a meeting. It not only helped to guide families, but it helped to guide us as facilitators to know what was the meeting going to look like, you know, at its core. Even though it was different for every family. I: It provided a basic structure. P: Yeah, and it really helped us feel comfortable in saying "hey," whether you are meeting with the	• Supporting the family • Family centered approach

	family inside or outside of the team meetings, it was all about what is going to work for them. And also what is going to, how do they see the process working for them. Yeah, a lot of families, especially in the beginning, actually throughout, the parents didn't want that judgement of like, what am I doing wrong with my kid, or what could I have done better. So the SRS actually throughout the two years really helped us to develop, like, this isn't about what you have done wrong, it is, what else could we do to help you guys to move forward to where you want to be.	
• Providing parents with positive self worth about their level of value and capability in the process • Team meetings encouraging positive outlooks for families	I: So it sounds like it kind of helped to remove some of the blame that parents sometimes feel when they are in a situation like this with their children. P: Yeah, and I think really helping give the family , especially the parents, more of that, you know, positive self worth, and like that positive, like "hey I can do this," and we are just in a bad spot, but we can, it really helped them to build their capacity. I: Right, and to kind of move forward and know that there are people who want to support them	• Family encouragement • Strengths focused • Removal of blame

	rather than criticize them.	
• Helping team members to understand the uniqueness of the process • All wraparound may not look alike • Team members also filling out SRS, participating in this part of the process • Help other members of the team to understand the purpose of this measure • Helped other team members to dedicate themselves more fully to the ideals of wraparound / the core focus	P: Right. And it was a helpful tool for team members, because we had a lot of people coming to the table who were saying "oh, we used to do wraparound," or "we know what wraparound is." And we kind of had to be like, okay, you don't, and so we were really helping the team members as well. Um, a lot of times when I would administer the SRS after the meetings, some team members would stay, and I would say to them, this is for the family to fill out, and sometimes I would let them share their opinions on the scales just to kind of see what they were saying. Like a cousin who was at the meeting or something like that. Um, but I explain to the team that this is a scale that we use so that we know as a team like what we could be doing better to help the family. So it really helped to dedicate the other members that were involved.	• Unique process • Inclusion of team members • Focus on common goals
• Some team members having the wrong idea about what these meetings were for • Having to redirect individuals who are not familiar with the strengths-based approach	I: Right, and to give them an idea about what the basis for these meetings even is. P: Right. And I had one meeting where it turned into, the director of special education came and talked	• Purpose of meetings • Coordinated effort

about the kid's IEP, and how awful he was doing, and how dangerous he is. And like that was not what the meeting was supposed to be for. So that was a pretty awkward conversation later, but.

I: Yeah, that does sound awkward, oh man! Well, that is pretty much all I had for you, I am glad we were able to connect, and I really appreciate you participating, this means a lot.

I: No problem, well good luck with everything!

Table 5

Transcript 3 of 4, Using Interpretive Phenomenological Analytic Methods to Analyze Data.

Exploratory Comments	Transcript Contents	Emerging Theme Titles
• Longstanding experience with grant, has been working with this program since it began	Interviewer: So this shouldn't take too much of your time, but just to start, I'm wondering about weight or experience has been within the program, like when you started, and so on. Participant: When I started, okay so we started I think we're going on my third year with the initial grant, so I started at that time with the first 3 coordinators. I don't remember the date. It was in 2014. I: In general has been, a coordinator or wraparound facilitator? P: Yes, exactly.	• Longstanding experience
• General feeling that using the SRS has been good • It seems like there are times when it isn't as appropriate to use the measure • Helping clients to understand why they are filling this measure out is important • Helping families to understand that feeling heard and understood is an important part of the process • Team meetings are	I: So I guess I'm going to just jump into my first question, and all of my questions are based around the SRS, which I think you guys have called the team meeting rating scale. P: Mmhm, yup. I: So my first question is, what has been your experience with administering the team meeting rating scale, and how did you help your clients to make sense of why they are completing it?	• Positive experience • Family centered approach • Family voice • Improvement of team meetings • Appropriateness of timing of administration

really for the families • Intent to improve participation in the team meetings	P: Umm, my experience using it, has been overall good. There are occasions when it's not appropriate. Sometimes team meetings don't and as you would have planned, and people can become tearful and that would not be the appropriate time to pull that out. However for the most part, is good. And you now, trying to help people understand the why of it, I just explained to them that it's just to ensure that they are being heard and understood as they need to be, and that the team meetings are for them. And so if we can kind of get some data around that, we can help to people to improve participation in the team meetings.	
• Making sure that the team is on track • If family is not feeling heard and understood, it is likely that meetings are not as successful as they could be	I: Got it, so it is helping the family to feel more understood. P: Yes, making sure that we are on track as a team, and going in the right direction. Because if people are not feeling those things that are listed in the rating scale, then we are not on track. I: Right, so families are a big part of that, and their feelings about the process are important. I really like the way you phrased that.	• Team meeting purpose • Family centered approach
• Scale administered at the end of each meeting • Team members are relatively familiar with the scale and how it	I: So my next question is, How has the inclusion of the team meeting rating scale in the wraparound session shaped the way you	• Team process • Component of meeting • Shifts in ratings • Making changes to

works • Significant changes in the rating scale would be brought up at the beginning of next meeting • Using changes in scale to reorient team to common goals • Not only brought up when scale is showing something negative • Also used as a way to celebrate successes, when teams are on track	approached sessions? So it sounds like sometimes he feels like it is not appropriate, but like how does it normally fit into the session? P: Do you mean when? Where? I: Kind of everything! P: We typically, as the meeting comes to an end, we identify our next meeting time and then I will administer this scale, to the family and youth, sometimes the team members are there, sometimes they're in the midst of leaving. So just depends. So everyone on the teams are pretty used to it, so they know it's a part of the meeting and if they would like to talk to the family they typically kind of wait. And then if there is any huge change in that rating scale, I would bring that to next team meeting. Just to remind the team that we are all working towards this common goal, for whatever reason if something's off. And then it goes in the positive continue, if the family is feeling much better, that's the reason to celebrate as a team.	team meetings • Strengths-based approach
• Scale administered at end of session, addressed at beginning of following session • Open, honest discussion of feedback gathered from measure • Review of ground rules	I: Right, so it could really go either way. So you administer it at the end of the session, and then you are kind of understanding the rating in between the end of the last session in the beginning of the next session.	• Openness and honesty • Feedback discussion • Scale informing process

of meeting if this is warranted • Use of scale to determine how to proceed and improve upon team meeting structure / overall feel	P: Yes. I: And had is a typically go when there is a rating that is not necessarily so great from the last session? How do you approach that? P: With the team? I: Yes. P: I would just approach it that, you know, the family's last meeting, whatever the specific thing was, I would just be open and honest with it. That we the team need to work harder at really making sure that everybody is feeling heard and understood and included, and that goes for all of the team members as well. Sometimes we will go back to our ground rules in the meeting, depending on what is off. That would indicate how he would use that to change or address any number of issues.	
• Ground rules as a way to further assist the team in proceeding • Unique ground rules for each team • Add ground rules as the meetings proceed if things come up that need to be addressed • Use of ground rules as a further reminder of the direction the meeting is going in • Rules not as a shaming mechanism, but as more of a collaborative	I: Okay. And can you say a little bit more about the ground rules? P: The ground rules are used, you know at the very first meeting, so that we all feel that we are making the best use of our time, everybody's time is valuable. So it helps guide the team as far as an agreed upon set of standards and rules that we want to include in our meeting. I: Got it. And are those the	• Family centered • Family uniqueness • Ground rules • Making changes to meetings • Collaboration

approach	same for every family, or you coming up with new ones for each team? P: We come up with those with each team. So one goal may be important to some people, may not be important to others. I typically has a few that I like to add. To include a like side conversations that I know sometimes makes the family feel uncomfortable. And also we will add to those as we go along and notice something coming up. If it doesn't feel good, and may feel little disruptive, we can add to those also, and we also use it to celebrate. You know, we decided on the set of rules and this team is really great at keeping things going, and being respectful, and just kind of using it to remind people where we are at and what direction we are going in. I: It sounds constructive, no matter how you use it. P: Yes, yes. Never to shame. Then people don't come back!	
• Usefulness of measure has to do with the ability of the measure to guide the team back on course • Families feeling bad if they are giving certain scores to the team • Family trying to be considerate and not hurt anyone's feelings • Lack of honesty /	I: We don't want that! So, my next question is, and what ways do you view the use of the team meeting rating scale as useful or not useful in informing what you do in the wraparound session? P: I would say, well I think I've talked about how it's useful. In that it kind of guides us if we are getting off course,	• Scale informing team progress • Scale informing team process • Inaccurate readings • Removal of blame • Emphasis on family voice / feelings • Age of youth • Meaningfulness of small changes

accurate results • Removal of blame from one specific person- it is more about the team as a whole • Emphasis on feelings, not facts- honoring family's perception of how things are going, and how the meetings are affecting them • Younger children- seems like they want to please coordinators, and therefore these responses feel even less accurate • Over time, changes are observed, even if they are only a couple of points off from one another • Small changes on this measure have meaning	it kind of helps us. In a way that it can be not useful, is a lot of times I think that families may feel badly about scoring it a certain way, that they don't want to hurt anyone's feelings. In that case, I find it to be not useful. Because, they're not being honest. And I just try to remind them that this is about the team as a whole, if not about any specific person, it is about a feeling and not a fact. I just try to remind them of those things and certainly knew no one would take any offense if they felt not good about a meeting, it's just use to help us in the future. Sometimes I find, especially with young kids, they really want to please you, you know, so I don't know if it's always accurate. However, over a long period of time, typically will find some kind of, where it ebbed and flowed a little bit. In the difference between the changes might be very small, but small changes can be meaningful.	
• Older children- measure may make more sense, but still feeling like this person runs into the same questions about accuracy • Observation of small differences over time • Eliminating the expectation that every meeting is going to be perfect	I: So do you feel like this measure is more useful with older children who participate in this model? Because it sounds like the younger ones had more trouble with it. P: Yeah, the younger ones, we typically give it to them too but I don't even know if they're kind of looked at for the younger kids. But I guess of course for the older kids	• Age of youth • Small meaningful changes over time • Score trends vs. one-time data

• Looking at one set of data does not feel like a good indicator of a whole team / family experience • Can more easily see trends over time for families	and can kind of makes sense a little bit more. But I think the same thing still happens, so I just look very carefully. So it could be a matter of the difference between a 9 or 10. It may not have to be a 2. So kind of watching that, and also knowing in the team knowing that every meeting is not going to be a ten. That is not always going to be. I: Right, that's not practical. P: Right, we are all human beings, and you know, we just try to look at it like that. I think overall is helpful, sometimes it is hard if you are just looking at 1 set of data, it is hard to kind of see any change or noticeable concern. I think over a longer period you tend to see trends.	
• Getting into the habit of completing the SRS helps families to know that it is part of the process • Coordinator keeping in touch with who this form is being completed for and who it is benefitting • If they are just doing it because it is a paperwork requirement without considering the family's needs, they are not serving the family in the best way • Considering the family's needs	I: Okay. And what about, I know that there is a lot going on in each of these meetings. Does the SRS ever feel like a burden, or like something that is an extra step? Doesn't ever feel like the family thinks "just another piece of paper work "? P: It can feel that way. It typically depends on the meeting. But I think if you do it initially and make sure that you get into the habit, the family becomes accustomed to doing it. So I don't feel that they look at it as a burden, it's just part of the process. Like I said sometimes is not	• Component of process • Appropriateness of administration • Benefit of completing scale • Family centered approach • Therapeutic indications • Consideration of family needs

	appropriate. So just keeping in mind, who I'm doing it for and the purpose of it. Is it for me for my paperwork and documentation? As a checkoff? Or is it for the family? And if it is for the family, then I have to do it at the appropriate time. I: So sometimes it sounds like if it's not feeling like a therapeutically appropriate time for the family, you kind of sacrifice your paperwork requirements? P: Exactly. I: So you really are considering the family's needs even in that way. So if it's not feeling like the right time, then you will do it in order to monitor the family's needs. P: Exactly.	
• Providing all family members with the SRS shows that all family members matter in the process • Specific example where parents worked together to fill out one form so that both of their voices could be captured • Facilitating family collaboration and voice	I: So the last question is, can you describe a specific experience where your use of the SRS was incorporated into your session in either a positive or negative way? Or both? P: I think for the most part, a specific example is, when the family, I typically give one to each of the family members even though we don't always use all of that data. We just use one parent. But it is a way to include all of the family voices, and sometimes mom and dad, for instance, we have a mom and dad who are co	• Family inclusion • Family voice • Facilitation of family collaboration

	parenting, they were not together. But what they did was they would negotiate this scores, so they really worked together. Because I tell them, I put the data for one parent. So they would negotiate for numbers, and it was really good for them, because she was really a super optimist, everything was always great. He was a little bit more pessimistic, seeing things in a little bit more of a negative light. So it was nice to see them come together to show me that they valued the information, and that they valued each other in the process. I would say that would be an example. I: Yeah, that sounds like a really positive example. You are facilitating family work in this process, it's all in the mix! P: It's all in a day's work!	
• Some families do not wish to complete this measure • Facilitator does not pry into the reasoning behind their refusal-respect • Respecting family / youth choice in the process, no forcing	I: And what about, have you ever administered it and then it went horribly wrong or it just was not received well? Or anything like that? P: Oh, I have had people refuse to do it, they just say no, they didn't want to. I: Oh, and you ever explore that more? P: No. Because that really is not my role. And of course I tell them that they can think about it and if they want to come back to it later they can	• Refusal to complete form • Respect of family choice • Non-judgemental stance

give me a text or call. And I just leave it there. And I think with youth, especially teens, without feeling forced, typically they will come around the next time. Sometimes they are just not in a good place or a good mood, and they do not want to be cooperative. And you know, there is a lot of especially with teenagers a lot of influencing coming at them about what they have to do. But I don't put myself in that position. I offered to them, let them know how I can be helpful, and if they don't want to do it they don't have to do it.

I: It sounds like you are really respecting the family's wishes in so many ways. Well, so that is pretty much all I had for you for today. I really appreciate you participating!

Table 6

Transcript 4 of 4, Using Interpretive Phenomenological Analytic Methods to Analyze Data

Exploratory Comments	Transcript Contents	Emerging Theme Titles
	Interviewer: So, the questions on going to ask you are based primarily around the team meeting rating scale which I am calling the SRS, it was just adapted for the setting you're in. So I have a few pointed questions for you, but I'm really just interested in kind of how your experience was overall as well, so feel free to add in whatever tidbits you feel like would be useful for me to know. Participant: Allright.	
• Longstanding experience with the grant • Was a part of the project for its entirety • Transformation into another, more supervisory-oriented role	I: So to start, can you just to tell me a little bit about your participation in this project? And how long you were participating, and what the nature of your participation was? P: So my role, I mean during the grant period, I was a coordinator for 2-1/2 years. So we started in 2014, and the Grant ended September 30, 2016. And are you asking specifically, about the rating scale? Or just my general experience? I: No, I'm just curious about your overall experience right now, your role was a coordinator during the grant period, correct?	• Longstanding experience • Transforming roles

	P: Yeah, so I was a coordinator and I was using all the tools, the wraparound tools, the evaluation tools. Yeah. I: Okay, and are you still participating in this project? P: Yes, so our practice has sustained but we are no longer in the grant period. The coordinators are housed under a different care management entity. My role has changed into program manager, so I do practice with families, I still has a few families left that I see her coordination. But my main role is to expand the program, and coach, and oversee other coordinators. I: Awesome, that sounds like somewhat of a promotion! P: Little bit!	
• Consistent use of scale over time- given after every team meeting • Perception that the scale was very easy to administer and complete • Scale being used as a way to tell how effectively the family is feeling helped by the team • Encouraging honesty / openness with the family's feedback • Measure incorporated into plan of care document • Observation of trends	I: That's exciting, so the upcoming questions are really about your role as a coordinator when you were in that position. So, my first question is what has been your experience with administering the team meeting rating scale and how to did you help your clients to make sense of why they were completing it? P: So, I used to, we used it every single team meeting that we did. I usually just set it up for the families that, first of all it was really easy, it was	• Consistency of administration • Ease of use • Honesty • Incorporation into family plan • Family voice • Scale as informing practice

means that the team can either celebrate, or go back to the drawing board to understand where improvements need to be made.	only for questions. So it only takes like 2 minutes to fill out so, it's really easy for families to complete. I kind of frame it that as it's just the way we are able to communicate how effectively the team is helping you, is helping the family. So I just frame it as for you to be able to be honest and open with feedback of how we are working for your family to meet those needs is really helpful. I would say I don't really exactly remember when, but we would incorporate the team meeting rating scale into our plan of care document. So right on the front of the plan of care there is an actual scale that shows the rating of the youth and the family every team meeting. If we start to see a trend, like it is going up or down, something to celebrate or talk about as a team if we need to improve somewhere.	
• Progress and outcomes are important, but it is more important for the family to feel like they are being supported in the best way possible • Measure gives coordinator the ability to have conversations about the team • Questions within scale prompt conversations • Without the scale the conversations may not come about as easily • Families become accustomed to filling	I: So it sounds like it's right on the forefront of the plan of care to, so it's something to pay attention to. P: Yeah, obviously we want progress and outcomes, but what really helps is for families to know that their team is strong and that they are supported. I think that's a huge accomplishment in general, something to celebrate. I: Yeah, so are you saying that the measure doesn't	• Family support • Strengths focused • Scale facilitating conversations • Ease of use

these forms out, becomes easier over time	necessarily tell you those things? Is it more about the report that you're getting from the family? Or those conversations where you are helping them to understand that there are team? Is that more meaningful than this measure? P: Well, I think that the measure gives us the ability to be able to have those conversations. So I don't want to say that the sessions are more reliable, but I think with those questions that we are able to ask within the session rating scale, or whatever it is called, I don't think we would be able to have many of those conversations. I: Got it. So the measure kind of helps facilitate the conversations. You can almost go back to it and say look, here's the rating what we think about this? P: Yeah, exactly. And again, I think it's nice, the families, after the second or third time of doing it, I don't even really need to read the questions anymore. They just kind of know. I mean, we will look at them of course. But families are pretty quick to just afterwards, they are like "10, 9, 8," or whatever the ratings are. I: It seems like they really get the gist of it.

• Focus on positive component of scale-coordinator wants to celebrate successes with families • Celebration of success for these families in particular is necessary and helpful • When the team is not as successful, it is important to make changes • Opens up a conversation about how to make improvements from the family's perspective • Always doing what is in the family's best interest	P: Right. Exactly. I: Yeah, great. So, my next question is how has the inclusion of the SRS in the wraparound session shaped the way you approached the session? P: Um, that's a good question. I think it's twofold in some ways. Really the biggest thing that we hope for is that we can celebrate the team coming together. I think that really it helps to shape the conversation that way. And any celebration for families that are exhausted and don't have hope is really helpful. I: Right, that's huge. P: That is huge. And I think that on the back side of that, when team have not necessarily come together with the family, the family feels that the team is supporting them in the best way that they can. I think it just opens up a conversation, to understand why and how we can get from an 8 to a 9. Or whatever number. I: In order to make improvements. P: Right.	• Strengths focused • Celebrate successes within the team • Positivity • Avenue for change • Family voice • Family's best interest
• Measure as not influencing coordinator to conduct themselves in a certain way • Use of coaching to help shape this coordinator's	I: And so, has knowing that the SRS was part of your deal, has that shapes the way that you had conducted yourself in these meetings at all?	• Use of coaching • Coordinator approach to team meeting

approach • Rating scale as a conversation piece	P: No, I wouldn't say that necessarily. I think that our practice and our coaching is really what helps us shape a lot of those meetings. More so than the rating scale, but I do think that we use it more as a conversation piece, like something that we can address specifically. And celebrate. Yeah I don't know, that's a tough one, I think there are so many parts and pieces about how we work as coordinators that I would not attribute this one measure to how it runs per se. But I think it's just a helpful frame for conversations.	
• Use of coaching to help coordinators to stick with the process and to be consistent • Use of coaching as a way to feel less stuck, alter approach to have more success with a family • Coaching as an essential part of the process- doesn't seem like it would work without it	I: So you mentioned coaching was a helpful part of the process. P: Yeah, I think that's probably, well I can think of a couple of really really important parts of our work as coordinators. But coaching is one thing that really helps us stick to the process. Specifically, and team meetings. But pretty much all parts of the process. It helps really frame it more than anything, the coaching. I: And so it sounds like right now you are in the role of a coach. But when you were a coordinator, that was you meeting with the wraparound coach and getting guidance and making sure that you are staying close to the model? That kind of a thing?	• Use of coaching • Improve approach • Essential nature of coaching

	P: Exactly. And I think with any part of the process really. If the coordinator is kind of stuck, or if it seems like there is little progress, or whatever the case may be. It is so different from family to family. Coaching is what really helps guide that. You know, they look for rating scales they look for benchmarks at all times just to see where we are at. And we don't make decisions with coaches for the family, but it just helps really direct the conversation, how we might help the family to move forward. I: It sounds like a really useful tool for coordinators to be able to fall back on. P: Yeah, I would say that it is certainly useful. And probably it would not work without it. I think that coordinators will be very lost without it.	
• View of the measure as positive overall- hard to find something un-useful about it • Feeling like an additional question about family's level of hope could be helpful	I: Okay, my next question is in what ways do you view the use of the SRS as useful or not useful in informing what you do with the wraparound sessions? P: Yeah, well I, this is probably redundant to the first question for the usefulness. I think that everything that I talked about already applies. For not useful, I don't necessarily see it as not useful. I think that, I don't	• Useful measure • Family hopefulness

	think that there is anything specific that I would say is not useful. I think all of it is useful. It is easy, it is quick, I think it captures pretty much all parts of the team meeting. I: So it's not missing anything. P: I don't think so. I mean if I really put my head down on it, there could be an extra question that could help pinpoint more specific experience around hope. And what is their feelings around hope, did they feel more hope after the team meeting, it may be helpful to have that in there. But it captures most of it already.	
• Difficult for family to be honest when completing measure • Family feeling as if they do not want to offend coordinator in any way by giving a low rating • Feeling that it could be more helpful for a person who is not the coordinator to complete the form with the family • Accuracy of results could be improved • Most meetings get rated relatively high, which makes coordinator question the accuracy • Families enjoying the team atmosphere, everyone there to support them • Coordinator and family having different feelings	I: Do you feel like it has ever been received poorly, or if it is burdensome at all? You are saying that it is super quick, but I also know from the other interviews that I've done that a lot goes into these team meetings and I'm wondering if there is a part of some families that almost feels burdened by this extra piece of paper work, or something like that? P: I don't think, it's not the burden of doing it. As I think about it, I think, the questions are really about the coordinator's ability to incorporate the family's voice in the meeting. So, I think sometimes for the coordinator to actually to ask them the questions, it is hard for the	• Honesty of responses • Accuracy of measure • Family enjoyment of team • Differing feelings about meetings

about how the meetings went	family as to necessarily be the most forthcoming. Like they don't want to hurt the coordinators feelings. Sometimes I feel like it might be even more helpful for maybe like a peer support to ask them. I: Instead of you? P: Yeah, so you might get a little more accurate results. I: Yeah that makes sense. Where there are times when you felt like families rated you super high when you yourself knew that the meeting did not go very well? P: Yes, I would say that most of the readings are pretty high all be honest. And I wonder, I know I've had some not great team meetings. And I personally would've rated some of the meetings lower. I think that families just like the team to be together, they feel supported. So they are typically on the higher side. I just, when the family gives a 10 for the first meeting, I feel like a 10 is perfect, it's just it does make me wonder. I: Yeah, like "how perfect was I actually?" P: Right, right. And especially if the meeting I know was not that great.	
• Coordinator not confronting families about their ratings	I: Right, and so do you ever like, do you take the ratings at face value, or are you able to	• Minimal confrontation • Conversations

• Brought up within the context of the team, not confrontational at all	say "hey I saw that you rated last meeting at 10, and that's off some but I am just really wondering if that is actually how you felt or if there is more to this?" P: I don't really dive too much into it, I don't necessarily analyze it unless the family wants to analyze it. The only way I will really bring it up is within the team. We don't necessarily analyze that together. I will just kind of bring it up as a team and we will talk about that together. That's typically how I use it anyway.	within team • Variability in ratings
• Incorporating youth voice into the team meetings was seen as positive • Helps the coordinator to share the child's views with the team- centered around this youth • Youth voice as a way to make improvements	I: Sounds good! And I have one more question, which is technically a two-part question for you. So it is, can you describe specific experience where you use of the SRS was incorporated into session in a positive, and then maybe also in a negative way, like where it didn't go over so well? P: Um, I think that some of the most positive is more so for youth voice. I feel like caregivers often feel pretty good because they understand the concept, I think what can get lost as when they uses on the younger side. And the processes pretty complex for someone who is 6. I think these questions are easy enough for a 6 or 7-year-old, where if they're giving their rating that is like a 4, it just	• Youth voice • Family voice

	helps the coordinator to share with the team to say we really need to make this easier and more understandable for this youth. And kind of brainstorm in coaching about how we can make this experience better, so that they can voice how they are feeling I guess. I: And also, I bet, helping him to feel that they are included more.	
• Noticing differences between caregiver and youth ratings helps to create a conversation • Facilitation of a discussion about where the disconnect is	P: Right, exactly. I think that that is probably the most helpful, other than the stuff that I already said. I think that sometimes seeing a difference between the caregiver and the youth is really helpful too. I: Can you say more about that? P: Um, I don't know, I am a family therapist by nature so when I see a disconnect, I don't want to necessarily use the word disconnect. I: Like a discrepancy? P: Yes, say like dad rates a 9, and the kid is like a 4. I think that's just a good talking point to say we are saying some real family dynamics around how things are being communicated and talked about. And just to see where the structure is different.	• Conversations within team • Variability in ratings
• Differing perceptions within one family unit • Focus on strengths of youth- being willing to	I: And so that opens up at greater conversation about the family itself and how they are perceiving things.	• Variability of ratings • Strengths- focused approach

rate the team meeting is in and of itself a brave action • Discovery of underlying issues within the family system when youth express that they are not feeling particularly heard	P: Right, and I tend to frame it like you know the youth is really being brave here to tell us that they are not feeling heard or whatever the question is. I: Right, that they are taking a risk and actually being honest. P: Right exactly. So, it's different it that way and a more positive way. Yeah, I think that's really what I look for. It doesn't happen that often, but I think it really brings out where the most underlying issues come from in those situations.	• Measure indicative of treatment considerations
• Coordinator's enjoyment of dissonance, viewing this as a means to change • Some team members find it difficult to receive low ratings • Team members as prideful, and when this feeling is challenged, some team members have difficulty.	I: And like, have you ever had an experience that set out to you that has been somewhat negative when the SRS has been used? Like have you brought the discrepancy up and things have not gone so well? P: Hm, that's a good one. I like dissonance, I like conflict personally, I think that's how things change and how things get done. So I don't think that there is a specific scenario where it has turned out bad. I think there are some team members that don't like to hear that they are not doing everything they can as a team to support this family. I: So that's hard for them to hear? P: I think that has been the	• Variability in ratings as a means to change • Pride in being part of a team • Variability in ratings • Scores taken personally

	case, certainly not all teams. I think certainly some team members have a lot of pride about what they do, and it is hard for them to hear that it is not going well as they thought it was. And to me that okay. I: And that is kind of what the nature of this measure is for, is to be able to talk about these things.	
• Coordinator finding it difficult to receive very high ratings from the beginning • Feeling as if there is no place to go, since ratings are already extremely high • Especially high ratings in the beginning make coordinator question what is actually going on for family • Questioning whether or not the coordinators should be the ones to administer these scales • Question about accuracy and honesty	P: Exactly. I had another example but I forgot it. Can you ask the question again? It might come back to mind. I: Sure! So the question is, continue describe a specific experience where the use of the SRS was incorporated into her session and a positive or negative way? P: I'm going to remember it now. There was another one that was good. I might remember it. I: Okay, no problem. But it sounds like your experience overall has been pretty good. P: Yeah, it's definitely good. I think, oh here we go, I remembered. What's hard for me the most is when, from the get go I am only getting 9's or 10's. To me, that's great, and that is something to celebrate. But for the first team meeting to maybe towards transition if I've gotten all 10's it just, to me, I don't want to say that's negative, but I don't feel like it's necessarily used the way it	• Dislike of high ratings • Accuracy of ratings • Administration of scale • honesty

	could be used. I: Right, because if you are getting a 9 or a 10 on the first session, it is almost like where do we go from here if everything is already almost perfect. P: Right, and you could chalk it up to the team meeting is really good from the get go, but it makes me wonder that's all. It's not negative necessarily but. I: But it sounds like that is a difficult point to get past when you are the being perceived as amazing on the first session. P: It just makes me wonder if the coordinators are the person who should be administering them. Some families are really honest, and some have a tough time. I: Which is understandable, because there is an inherent power differential that happens in these situations. P: Right.	
• View of SRS as helpful in multiple clinical settings • Ease of use, view of measure as helpful for the therapeutic alliance	I: Well, that was all of the questions I had for you, unless there was anything else that would be useful for me to know, otherwise that is about it. P: No, I don't think so. I think to be honest, as a clinician, it would be, I have been in clinical roles for a lot of	• Scale as useful • Ease of use • Therapeutic alliance

years. It would almost be nice to have like a clinician for clinical role ask that after every session honestly. I think it's helpful for any client, family, or youth, whoever is getting therapy to use something like that.

I: Yeah, so in an individual therapy setting, or even like a family therapy setting?

P: Yeah, any session I think. Because it is so quick and easy to use, and it is a good way to gauge, even if it is just writing on paper, and folding it up, and looking at it. Even if the therapist looks at it afterwards, I think it's helpful to direct the relationship. I got a little bit more soap-boxy but I think for our practice that's really cool. It's a nice tool, and it's really easy to use.

I: Well I am glad you have had such a positive experience with it. That's really nice to hear. Alright, will thank you so much for participating, I really appreciate it!